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ADJUSTMENTS IN MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

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ADJUSTMENTS IN MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

WEDNESDAY, AUGUST 8, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice at 10:10 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press release announcing the hearing, the opening statements of Senators Dole and Durenberger and the background paper prepared by the staff follow:]

[Press Release, Committee on Finance, July 11, 1984]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON ADJUSTMENTS IN MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

Senator Dave Durenburger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on adjustments being made by the Secretary of Health and Human Services to the diagnosis-related group (DRG) relative weights used to compute Federal payment rates under Medicare's prospective payment system.

The hearing will be held on Wednesday, August 8, 1984, beginning at 10 a.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing Senator Durenberger noted that "when Medicare's propsective payment system was enacted, the Congress directed the Secretary to assign an appropriate weighting factor to each DRG to reflect the relative hospital resources used with respect to discharges classified within each group compared to discharges classified within other groups. Furthermore, the Congress directed the Secretary to adjust the DRG classifications and weighting factors for discharges in fiscal year 1986 and at least every four years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. The Prospective Payment Assessment Commission was created, for the most part, to advise the Secretary with respect to the ned for such adjustments."

Senator Durenburger further noted that "the Secretary has announced her intention to deflate the relative weight of each DRG for fiscal year 1985. This is being done on the basis that the Secretary's expectation of an increase in the hospital case mix index for 1984 fell short of what was actually experienced. Representatives of the hospital industry have expressed concern that this proposed adjustment will result in payment rates lower than those which would have otherwise been set to satisfy budget neutrality. There seems to be a general feeling that not enough is known about how changes in the case mix index have been measured and applied. The purpose of this hearing is to provide the Subcommittee with an opportunity to review the concerns expressed by the industry and afford the Department with an opportunity to present its case for the proposed adjustment."

Opening Statement of Senator Bob Dole

October 1, 1983, marked the beginning of a new payment system for hospital inpatient services under the medicare program. Under the new prospective payment system, hospitals are afforded real incentives to become efficient and cost effective providers of care. The incentives are beginning to work and will continue to work so long as both the hospital industry and medicare patients understand the principles on which the new payment system is based and continue to view the new system as a viable and positive alternative to cost reimbursement.

Viability is certainly key to the successful implementation of the system. Maintaining that viability depends on the perception among hospitals and patients that the system is both fair and equitable. Where there is a problem with the system that can be fixed, it is in all our best interests to take the action necessary to put the system right. Subsequent to the passage of Public Law 98-21, I made it clear that I intended to follow closely the implementation of this new system and would be interested in making appropriate changes as they became necessary and possible so as to assure that the system in place was the most equitable possible. Of course, we must keep in mind our real desire to change the economic incentives for many hospitals, so they are encouraged to provide the highest quality care while keeping a close eye on the cost of that care. However, it has been brought to my attention that as a result of the Secretary's proposal to modify the payment rates for fiscal year 1985 the perception of fairness and equity on the part of some has waned.

I, as well as others, am unsure about what has been proposed and whether the budget neutrality constraint imposed by the Congress requires the so-called deflation of the drug weighting factors.

I look forward to the administration's testimony with the expectation that a better understanding of what has been proposed will lead to a restoration of confidence in a payment system that, in conjunction with an effective program of utilization and quality review, will assure access to efficiently provided quality care for elderly and disabled Americans.

Opening Statement of Senator Dave Durenberger

Much concern has been expressed about the modifications the Department of Health and Human Services has projected for the 1985 fiscal year payment structure of Medicare's prospective payment system. The purpose of the hearing today is to examine the Department's rational for proposing these modifications and to shed light on the methodology used by the Department in setting the increase in DRG payments for the upcoming fiscal year.

In 1983, the Congress adopted this new payment system for hospital inpatient care under Part A of Medicare. The new system was designed to shift incentives for hospitals by providing for a lump sum payment to these institutions per episode of illness rather than for payments based on a set of itemized costs incurred. The new system encourages hosptials to offer services to Medicare beneficiaries in a more cost effective manner. It is not a perfect system but the hospitals have accepted its challenge. It is a constructive first step in the reform of Medicare.

In adopting this reform, the Congress sent a clear signal to the health industry as a whole that the federal government will not continue to operate on a cost based reimbursement system for Medicare services in the future. Instead, the federal government, in its role as a prudent purchaser for its beneficiaries, will begin moving toward a payment mechanism for all Medicare services based on the unit of an episode of illness.

To successfully develop and implement those new payment mechanisms, however, both the hospitals and the other health care providers must be assured that the "rules of the game" for these systems will be objective, realistic and consistent. If health care providers can not have confidence that the federal policies will be true to these principles, there is a danger that the usefulness of the system may be undermined.

To sustain this confidence and the momentum that has been achieved in the first year of the program for hospitals, it is critically important that changes in the payment structure—such as we will discuss today—are made completely in the open, and that these changes are perceived as fair as well as meeting the requirements of the law.

In the future, the prospective payment system we have adopted for hospitals will reduce the cost of the Medicare program. The Congress, however, did not anticipate that savings would be achieved in the initial years of the new system and, clearly, did not want the transition to increase costs as new approaches sometimes do.

Therefore, the Congress directed that the aggregate payments for Medicare under prospective payment should remain at the levels projected for the same services under prior law. The Congress additionally allowed in the legislation for a yearly increase in payments equal to the market basket of goods and services for hospitals plus another one percent to compensate for the technological advancement.

The hospital industry accepted these terms for the transitional period to the full implementation of the prospective payment system in 1986. In light of their cooperation with and commitment to the new program, it is especially important that new payment structures designed to implement these provisions of the law do not make assumptions which may inappropriately hold down the overall funding levels. To do this the confidence of all health care providers in the new payment approaches might be threatened as well as the long run success of converting the manner in which Medicare pays for all services.

The witness list for the hearing today is necessarily short. It is limited to the Department not because we wish to be exclusive but because we feel the Department alone can best provide the background on what it has proposed and why. Testimony from others would only offer speculation and it is the purpose of this hearing simply to clear the air on the Department's intent in proposing modifications in the Medicare payment structure.

I appreciate the willingness and the time the hospital industry has devoted to review the changes proposed by the Department and assure them that their concerns will be addressed in our discussions here today. I look forward to a continuing dialogue with the industry in this matter and others that may arise as we refine and improve the new payment system for Medicare.

THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT RATES PROPOSED FOR FISCAL YEAR 1985

Background Paper

Prepared for the Use of the Members of
The Senate Committee on Finance

August 1984

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INTRODUCTION

The Secretary of Health and Human Services (HHS) published a notice in the Federal Register, on July 3, 1984, which describes proposed changes in the Medicare hospital prospective payment system (PPS). In addition, the notice describes the methods, factors and amounts proposed for use in determining the hospital payment rates for fiscal year 1985.

These methods include a controversial adjustment to the DRG weighting factors (explained below) which has the effect of reducing the payment rates by 2.4 percent. According to the Administration, this adjustment is intended to compensate partially for a projected increase in aggregate FY 85 payments resulting from an increase in reported hospital case mix under prospective payment compared with the 1981 base year data.

The Subcommittee on Health has scheduled a hearing on Wednesday, August 8, at 10:00 a.m. to provide the members of the Committee an opportunity to question the Administration regarding the proposed regulations. This document has been prepared to assist you in reviewing these regulations and the issues that have been raised by the hospital industry.

BACKGROUND

The Social Security Amendments of 1983 (P.L. 98-21) established a prospective payment system for payment of hospitals for inpatient services provided to Medicare beneficiaries. This system has the following major features:

- Prospective rate per discharge. Hospitals are paid a predetermined fixed price per discharge for each type of patient. Each patient discharge is classified (on the basis of discharge diagnoses, surgical procedures, age, sex and discharge status reported on the inpatient bill) into one of 468 categories, called Diagnosis Related Groups (DRGs). The hospital receives a predetermined fixed price per discharge in each DRG. In effect, the hospital is paid according to its currently reported mix of cases among the DRGs.

- Payment of nonoperating costs. DRG prices or rates are related to the operating costs of treatment in each DRG category. Nonoperating costs, i.e., capital costs and direct medical education costs, continue to be reimbursed on a retrospective, incurred-cost basis.

- Additional payments. Hospitals receive additional payments for outlier cases (unusually long length of stay or extraordinarily high cost) and for the indirect costs associated with graduate medical education activity (interns and residents). These payments are financed by a proportionate reduction of the DRG payment rates for all hospitals, determined on an aggregate basis.

- Phase-in. Hospitals become subject to this system (phase-in) for discharges occurring in their first cost reporting period (hospital fiscal year) beginning on or after October 1, 1983.

- DRG rate formula. The DRG payment rates are generally determined by the product of three components:

    1) a standardized payment amount which represents the average operating cost of treatment for a typical Medicare inpatient stay in the base year data (1981) updated for inflation to the year in which the payments are to be made (e.g., FY84 or FY85). It is based on hospital operating cost data for 1981 adjusted (standardized) for differences across hospitals in: case mix 1/ (the 1981 case mix index); wage levels (the 1981 Bureau of Labor Statistics wage index); and teaching activity (the teaching adjustment). Thus, the standardized payment amount represents the average operating

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1/ Each hospital's case mix is defined by its mixture (relative proportions) of Medicare discharges among the DRGs. Since the types and quantities of resources required in diagnosis and treatment vary across DRGs, the hospital's proportion of discharges in each DRG is weighted by a measure of the relative costliness of a typical Medicare discharge in that DRG (the DRG weighting factor). The hospital's case mix index, which is the sum of the weighted proportions of its discharges across all DRGs, is a measure of the relative costliness of its mix of discharges compared to the national average mix of discharges among the DRGs in all hospitals.

cost per discharge that would be expected if all hospitals had the same mix of cases (across DRGs), paid the same national average wage rates and had no teaching programs.

2) A wage index which measures the average wage level in each urban area (Metropolitan Statistical Area) or rural area (nonmetropolitan counties of a State) relative to the national average wage level across all areas.

3) A weighting factor for each of the DRGs which is an index number (e.g., 2.3558 or .8261) which reflects the relative costliness of a hospital discharge in the DRG compared to the typical Medicare discharge. These weights are based on estimates of the national average operating cost per discharge in each DRG derived by combining data from a large sample of 1981 Medicare bills with 1981 cost report data for each hospital.

The payment rate for any individual DRG for a particular hospital would be obtained by the following (simplified) formula:

DRG rate = (Standardized payment amount) x (wage index for the hospital's area) x (weighting factor for the DRG).

The standardized payment amount controls the overall level of the payment rates for all hospitals, the wage index adjusts the level of the payment rates to reflect differences in wage levels across geographic areas and the DRG weights control the relative levels of the payment rates across different types of cases.

- Urban/rural distinction. Payment rates are further differentiated according to the location of the hospital in an urban or a rural area. A separate standardized payment amount is calculated for: 1) all hospitals located in Metropolitan Statistical Areas, and; 2) all hospitals located in non-metropolitan counties.

Two important provisions control both the timing and the manner of implementation:

- Transition. During a three-year transition period, the DRG payment rates for each hospital are based on a transition payment amount (TPA) which is composed of varying proportions (blends) of regional and national standardized payment amounts and a hospital specific payment amount (reflecting the historical cost experience of the individual hospital). Hospital operating costs per discharge (and historical reimbursement per discharge) vary substantially among geographic regions and among hospitals within regions. Blending component payment

amounts that reflect these differences and gradually shifting the relative shares of the components helps to ease the transition from hospital specific, retrospective, cost reimbursement to prospectively determined, national average payment rates.

o Budget neutrality. During the first two years, this system is also required to be budget neutral with respect to the provisions of prior law. The PPS payment rates must be set so that aggregate payments to hospitals included in the payment system during Federal fiscal years 1984 and 1985 are neither more nor less than the aggregate amounts that would have been payable to these hospitals if the provisions of prior law (Section 1886(a) and (b) of TEFRA, P.L. 97-248) had remained in effect. This provision has several implications:

1) Since the PPS payment rates are set in advance of the period to which they apply (prospective), the budget neutrality determination and any necessary adjustments must be estimated in advance; budget neutrality is prospective rather than retrospective.

2) The budget neutrality determination is based on a comparison of aggregate payments projected under PPS with aggregate payments projected under TEFRA for discharges from PPS hospitals in Federal fiscal years 1984 and 1985. However, both the PPS system and the applicable provisions of TEFRA change by law between these years due to the transition provisions and phase-in of hospitals in both systems. Therefore, the budget neutrality comparisons and the necessary adjustment factors must be estimated for each year separately.

3) Since the PPS payment rates during these years are based on composite transition payment amounts, overall budget neutrality can be assured only if each component (i.e., the regional, national or hospital specific amount) is adjusted to be budget neutral by itself. If each component is budget neutral, then any blend of components also will be budget neutral.

4) A change in any factor (e.g., aggregate hospital utilization behavior, hospital reporting practices, etc.), which is expected to change aggregate PPS payments relative to payments under TEFRA, must be offset by an equivalent adjustment to the PPS payment rates.

THE PROBLEM

The budget neutrality provision requires the development of separate adjustment factors for each component of the transition payment amount (i.e., the national and regional standardized amounts and the hospital specific payment amounts) and for each year (FY84 and FY85). The Administration argues that the problem arises because the estimated increase in hospital case mix (due to a shift in reporting toward more costly cases) used in developing the FY85 adjustment factors was higher than the estimate used to develop the FY84 adjustments. As a result, they conclude that an additional adjustment is needed in establishing the FY85 rates.

They also argue, however, that the additional adjustment must be applied to the DRG weights rather than to the component payment amounts directly (through the budget neutral adjustment factors). This contention is based on the way in which the timing of changes in the hospital specific payment amounts during the transition period and the phasing of hospital cost reporting periods interact with the budget neutrality determination for FY85.

The process of budget neutrality determination and the role of case mix increase estimates in that process are described for each year below. The interaction of the transition provision and the phasing of hospital fiscal years with the budget neutrality determination is explained in Appendix A.

Budget neutrality in FY84

In determining budget neutral adjustment factors for the FY84 rates, aggregate PPS payments under both components of the transition payment amount (i.e., the regional standardized payment amount and the hospital specific payment amount) 2/ were modeled separately using the 1981 base year cost and

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2/ The national standardized payment amount is not a component of the FY84 transition payment amount.

billing data, adjusted and updated for inflation to correspond with Federal fiscal year 1984. The model consists of the following general formula:

> Aggregate PPS payments = (each hospital's component payment amount) x (its case mix index) x (the number of discharges it had during the year) summed over all hospitals.

In order to determine the budget neutral adjustment factor for the regional standardized payment amounts, for example, each hospital's regional payment amount (adjusted by the hospital's area wage index, etc.) would be entered in the formula, along with its case mix index value and its volume of discharges. The total payments projected for each hospital (as if all payments were based on the regional standardized payment amount) would be added together with the results for all other PPS hospitals to obtain aggregate payments during Federal FY84.

Projected aggregate PPS payments for each component payment amount were compared separately to a projection of aggregate payments under TEFRA, for the same Federal fiscal year, in order to derive a separate budget neutral adjustment factor for each component of the PPS transition payment amount.

The case mix index values used in the PPS model were based on billing information reported in 1981. At that time, the patient diagnostic information necessary for DRG assignment was completely unrelated to payment. As a result, the 1981 bills contain a variety of errors which tend to cause the hospital case mix values to be understated. Hospital PPS payments, however, are based on the diagnostic information reported on the current bills, under very different incentives. Therefore, an increase in overall hospital case mix under PPS was anticipated.

The formula in the aggregate payment model implies that any increase in reported hospital case mix index values will increase aggregate PPS payments in the same proportion. Since payments to hospitals under TEFRA would not be

affected by a change in reported case mix 3/, potential changes in reporting threaten the accuracy of the budget neutral adjustment factors.

Therefore, an attempt was made to estimate the overall increase in case mix that could be expected as a result of better reporting. An estimate of 3.38 percent was obtained by comparing an overall case mix index based on the 1981 billing data with an overall index based on more accurate diagnostic data submitted by all active Professional Standards Review Organizations during the same period. This estimate was incorporated into the budget neutral adjustment factors that were applied to the regional standardized payment amounts and the hospital specific payment amounts in setting the PPS rates for FY84. Thus, the payment rates were reduced 3.38 percent (by reducing the transition payment amounts in the rate formula) in order to offset the 3.38 percent increase in aggregate payments expected from the change in reported case mix.

Budget neutrality in FY85

A similar process was employed in determining budget neutral adjustment factors for the proposed FY85 PPS rates. Projected aggregate payments under PPS for discharges occurring in Federal FY85 for each of the three components (regional, national and hospital specific) of the transition payment amount were compared separately with projected aggregate payments under TEFRA for the same period. This time, however, it was possible to estimate the increase in case mix by directly comparing the current case mix, based on the actual reporting experience under PPS (bills submitted by PPS hospitals through March 1984), with the case mix reported by the same hospitals for the comparable

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3/ The limits on the reimbursement of total operating costs per discharge (Section 1886(a) of TEFRA) would be adjusted to reflect case mix differences across hospitals on the basis of historical rather than current case mix information. The target rate of increase limits on operating cost per discharge (Section 1886(b) of TEFRA) would be completely unrelated to hospital case mix. It is likely, however, that exceptions would have been allowed for changes in case mix due to extraordinary circumstances in some instances.

period in the 1981 base year data. The estimated increase turned out to be 5.85 percent, 2.4 percent higher than the earlier figure.

Although valid methods were employed in estimating this change, the result may be inaccurate for two reasons. First, it could be understated due to the effects of lags in billing. If the more serious and expensive cases are reported with a longer delay, then the current PPS bill file will underrepresent types of cases with relatively high DRG weights and the increase in case mix would be underestimated. Second, the increase in case mix could be either over or underestimated if the large, urban, teaching hospitals, which tend to phase-in later (and are underrepresented in the current bill data), have a different experience than the hospitals that entered the PPS system early in FY84. For example, the quality and completeness of the clinical information submitted by large teaching hospitals in 1981 may have been significantly better than average, leaving less room for improvement (and a smaller percentage increase) between 1981 and 1984. The size of these effects, however, is unknown.

If this estimate is accurate (and all other projection assumptions hold), then aggregrate PPS payments to hospitals for discharges occurring in FY84 will be approximately 2.4 percent higher (roughly $300 million) than strict budget neutrality would permit. Since budget neutrality is prospective, however, the Department has made no effort to recover any excess payments for FY84.

According to the Administration, the need for an additional adjustment to the FY85 PPS rates is dictated by the higher estimate for increases in case mix under PPS. As a result of their estimates, and in order to avoid exceeding the aggregate payment level allowable under budget neutrality for PPS discharges occurring in FY85, the Department reduced the FY85 payment rates by an additional 2.4 percent (compared to the 3.38 percent case mix adjustment applied in FY84).

This additional adjustment was not applied to the transition payment components (through the budget neutral adjustment factors) as in FY84. Instead, the 2.4 percent reduction was applied directly to the DRG weighting factors. Thus, for FY85, a 3.38 percent adjustment for increases in case mix was applied in the budget neutral adjustment factors and a further 2.4 percent adjustment was applied through an across the board reduction of the DRG weights.

THE POLICY OPTIONS

The adjustment required to maintain budget neutrality could have been applied, however, in three different ways:

1) The entire 5.85 percent reduction could have been applied to the budget neutral adjustment factors for FY85 (just as the 3.38 percent adjustment was applied in FY84);

2) The entire 5.85 percent reduction could have been applied to the DRG weights, or;

3) The adjustment could have been split (as the Department decided) between the budget neutral factors and the DRG weights.

The Department's rationale for selecting the third option rests on the argument that the remaining options have more serious undesirable consequences. The first option could actually reduce the hospital specific payment amounts in FY85 below the level set in FY84. In addition, this first option would continue to reduce payments to hospitals during Federal FY86, after the budget neutrality requirement has expired. Moreover, the amount of the reduction in aggregate payments over both FY85 and FY86 would be approximately twice as large as the amount required to achieve budget neutrality in Federal FY85. The second option (a 5.85 percent reduction in the DRG weights) would compound the budget neutrality adjustment set in FY84. In effect, this option would reduce the hospital specific payment amounts for many hospitals by more than 9 percent

for part of Federal FY85. It would also reduce aggregate PPS payments in Federal FY85 below the level required for budget neutrality.

These effects would occur because of the interaction between the timing of changes in the transition payment amount, the phasing of hospital reporting periods and the budget neutrality determination for Federal FY85. An explanation of that interaction and an analysis of the effect of each option are presented in Appendix A.

INDUSTRY ISSUES

Representatives of the hospital industry have raised several issues regarding the proposed adjustment of the DRG weighting factors.

Statutory Authority

First, some industry representatives have questioned whether the Secretary of HHS has the authority to adjust the DRG weights to achieve budget neutrality. They argue that Section 1886(e)(1) states that budget neutrality is to be assured by adjustment of the percentage increase applicable for updating the hospital specific portion of the payment rate and by direct adjustment of the regional and national standardized payment amounts before applying the weights. Further, they cite Section 1886(d), which describes the rate construction process, to argue that budget neutrality adjustments should apply to the payment amounts rather than to the DRG weights.

Nature of the Change in Case Mix

Second, many in the industry argue that some portion (perhaps the major part) of the measured increase in hospital case mix from 1981 to 1984 represents a real change in the mix of inpatient cases treated by hospitals. Both the aging of the beneficiary population and the trend toward greater use of ambulatory

instead of inpatient care are cited in support of the hypothesis that the Medicare inpatient case mix has become more costly over time.

The implication of this argument is that real changes in case mix should not trigger a corresponding adjustment to the rates since the rates would then be too low to cover the increased cost of care. This would force other payers to subsidize the Medicare program. Further, they argue that it also would counter efforts to encourage substitution of less costly alternatives for inpatient care.

Moreover, industry representatives point to public statements by HCFA officials that reductions in the DRG cost weights will be made annually to counteract any increase in case mix. They contend that this establishes a policy of transferring from government to providers the financial risk for changes in severity of illness in the beneficiary population, and that this policy is unfair and not contemplated in the statute.

Case mix, TEFRA and budget neutrality--Others have taken the second argument much further by contending that real changes in case mix would have been recognized under the TEFRA reimbursement limits as a legitimate source of increases in allowable costs. The language of Section 1886(b)(4)(A) is cited to indicate that hospitals experiencing an increase in case mix could receive an exemption, exception or adjustment to the otherwise applicable limits on total operating costs per discharge payable under TEFRA.

In the context of the budget neutrality determination, this would mean that aggregate payments under both PPS and TEFRA would be affected by real changes in case mix with the result that the adjustment required in order to achieve budget neutrality would be less than 5.85 percent.

Adequacy of the data used to estimate changes in case mix--Industry spokesmen also have questioned the adequacy of the 1984 billing data to support a valid and accurate estimate of the increase in case mix. They contend that the 896,000 bills used by HCFA represent less than a 20 percent sample of all discharges reported from PPS hospitals during the first six months of operation of the payment system. Moreover, the hospitals included in PPS during this period represent only 43 percent of the total number of PPS hospitals.

Industry representatives argue that these limitations on the currently available data are likely to result in a biased estimate of the increase in case mix. In particular, they cite the fact that the remaining 57 percent of PPS hospitals not represented in the data include a disproportionate share of the large teaching hospitals which tend to treat relatively complex and expensive cases. They also cite the two months of unusually severe winter weather that occured during 1984 which could affect any estimate based on the current limited data. The implication is that the 5.85 percent increase in case mix estimated on the basis of these data may not turn out (when complete data are available) to be particularly reliable.

Access to Key PPS Data

Finally, the industry argues that the Department has repeatedly failed to provide sufficient information (including underlying data and supporting studies) to permit industry analysts to evaluate and react to the methods and proposals of the Administration under this system.

APPENDIX A

Transition Timing, Phasing of Hospital Reporting Periods and Budget Neutrality in FY85: The Effects of the Options

The timing of changes in the amounts and the blend of the components of the hospital transition payment amounts and the phasing of hospital cost reporting periods interact with the budget neutrality determination for FY85 to produce different effects for each rate adjustment option. In order to understand these differences, it is necessary to examine the scheduled transition and how it applies to hospitals with different accounting years.

Transition blending and timing of TPA components

During the three year transition period (which begins with the hospital's first cost reporting period beginning on or after October 1, 1983) the transition payment amount (TPA) is a changing blend of three components: 1) a Federal regional standardized payment amount (separate amounts for urban and rural hospitals located in each of the nine Census divisions); 2) a Federal national standardized payment amount (separate national averages for all urban hospitals and all rural hospitals, respectively), and; 3) a hospital specific payment amount (based on each hospital's historical cost experience in a base year). The regional and national standardized amounts are blended together to form the Federal portion of the TPA. Once a hospital enters the PPS system, the Federal portion of the payment amount is applied in payment for all discharges that occur during the Federal fiscal year. The Federal rate blending factors change and the standardized payment amounts are updated

for inflation at the beginning of each subsequent Federal fiscal year starting with FY85.

The Federal portion is blended with the hospital specific amount to form the TPA used in the rate formula. The transition blending factors, which govern the shares of the Federal portion and the hospital specific portion in the TPA, change with the beginning of the hospital's fiscal year or cost reporting period. The hospital specific portion (amount) is updated for inflation at the same time.

The Federal rate blend factors, the transition blend factors and the timing of their application are summarized in Chart 1.

Transition timing for hospitals with reporting periods matching the Federal fiscal year

Roughly 20 percent of all included (PPS) hospitals have a cost reporting period that begins on October 1 (i.e., matches the Federal fiscal year). Thus, for each of these hospitals, the Federal and transition blending factors and the levels of the Federal and hospital specific portions will be constant during the entire fiscal year, resulting in a single set of DRG prices applied to all discharges that occur during the year. This situation is illustrated, along with the calculation of the transition payment amount, for hospital A in Chart 2. This hospital enters its first transition year in the PPS system at the begining of Federal fiscal year 1984. Its transition payment amount is a blend of 25 percent of the blended Federal portion (FED84) and 75 percent of its hospital specific portion (HSP84). At the beginning of Federal fiscal year 1985 the Federal standardized payment amounts and Federal blending factors change (resulting in a new Federal portion-FED85) and the hospital's HSP amount (HSP85) and the transition blend factors also change.

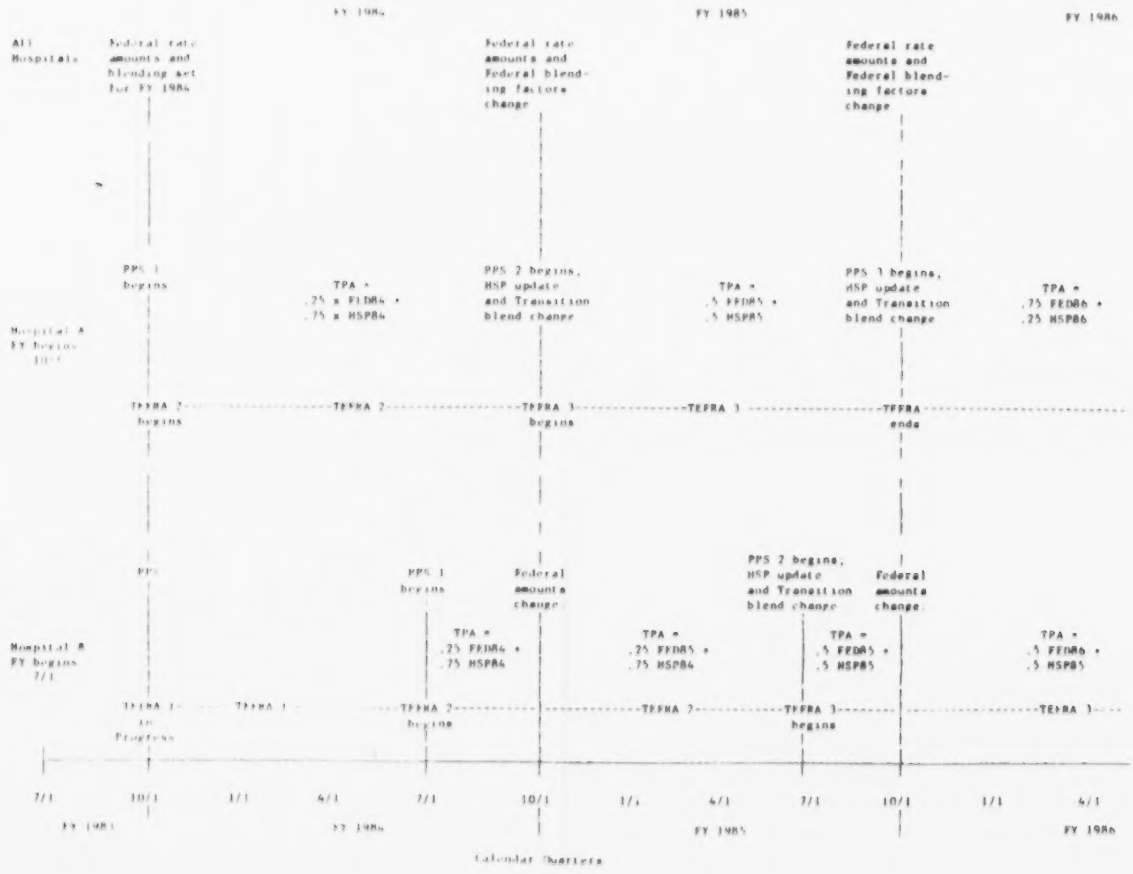
CHART 1. Federal and Transition Blend Factors
and Timing of Transition Changes

Transition Year	Federal Blend Factors			Transition Blend Factors		
	Timing*	Regional	National	Timing**	Federal	Hospital Specific
1	Federal FY84	100%	0%	Hospital FY	25%	75%
2	Federal FY85	75	25	Hospital FY	50	50
3	Federal FY86	50	50	Hospital FY	75	25

* Effective for discharges occurring throughout Federal fiscal years 1984, 1985 and 1986, respectively, beginning with the hospital's first cost reporting period that begins on or after October 1, 1983.

** Effective for discharges occurring throughout hospital cost reporting periods (hospital fiscal years) that begin during Federal fiscal years 1984, 1985 and 1986 repectively.

CHART 2 - Transition Phasing and Blending for Federal and Hospital Specific Portions of PPS Rates and Phasing for TEFRA



Transition timing for hospitals with nonmatching reporting periods

For the 80 percent of hospitals with nonmatching accounting years, however, the situation is different, as illustrated by hospital B in the chart. The update of this hospital's HSP amount and the change in the transition blend factors occur at the beginning of its second PPS transition year, July 1, 1985. This results in payment for three-quarters of Federal fiscal year 1985 on the basis of the first year transition blend of 25 percent of the blended Federal portion for FY85 (FED85) and 75 percent of the hospital specific portion set in Federal fiscal year 1984 (HSP84). By implication, only about one-quarter of this hospital's discharges during Federal fiscal year 1985 will be paid at the FY85 hospital specific rate and blend. That is, the hospital specific portion for FY85 (HSP85) applies for only a fraction of the discharges during Federal fiscal year 1985 in these hospitals, and when it does apply, its relative importance in the transition payment amount is reduced from 75 percent to 50 percent (due to the change in the transition blend factors).

The interaction of transition timing for the HSP with budget neutrality

According to the Administration, this is the crux of the problem in dealing with the additional increase in case mix to achieve budget neutrality during Federal FY85. The 2.4 percent increase in case mix will increase aggregate payments to hospitals by 2.4 percent during the year for each component of the transition payment amount. The budget neutral adjustment factor for the hospital specific portion of the payment amount for FY85, however, will apply to only a fraction of the HSP based payments for discharges occurring

in Federal FY85. 1/ Therefore, the budget neutral adjustment factor for HSP85 would have to be set much higher than 2.4 percent in order to offset the 2.4 percent increase in aggregate HSP payments during the year.

This can be seen in the formula for aggregate payments based on the hospital specific portion in FY85.

Aggregate HSP payments in Federal FY85 =
{[(HSP84) x (the share of discharges in FY85 paid on the basis of HSP84) x (the blend factor (.75) for HSP84] +
[(HSP85) x (the share of discharges in FY85 paid on the basis of HSP85) x (the blend factor (.5) for HSP85)]} x
(the hospital's case mix index) x (1.024) x (the number of discharges expected during FY85) summed for all PPS hospitals.

The HSP84 reflects the applicable budget neutral factor for FY84 including the 3.38 percent case mix adjustment. This amount is fixed, so the amount in the first pair of internal brackets (the HSP84 carryover which is not affected by the FY85 HSP budget neutral adjustment) is fixed. The 2.4 percent (1.024) additional increase in case mix, however, applies to the whole amount of aggregate HSP payments in FY85, not just the payments made on the basis of HSP85. Thus, if the increase in aggregate payments is offset through the budget neutral factor for HSP85, then the entire amount (2.4 percent of aggregate payments) must be taken from the amount in the second set of brackets (underlined). This amount, however, represents only about 48 percent of aggregate payments based on the HSP during FY85. Therefore, the budget neutral factor for the HSP in FY85 would have to reduce the HSP85 amounts by about 5 percent (2.4 ÷ .48) in addition to the 3.38 percent adjustment required to offset the original estimate of the increase in case mix.

1/ Since the Federal components of the TPA apply for the whole Federal fiscal year, the budget neutral adjustment factors for these components apply to all Federal rate-based payments for discharges during Federal FY85. Thus, a 2.4 percent adjustment would completely offset the 2.4 percent increase in Federal rate-based payments due to the additional increase in case mix.

Analysis of Option 1

Based on this analysis, the Administration has identified several undesirable consequences of offsetting the whole 5.85 percent increase in payments through the budget neutral adjustment factors. First, the HSP amounts in 1985 (after adjustment) could actually decrease compared to the 1984 HSP amounts. Second, this option would produce fairly substantial inequities across hospitals during FY 1985. Hospitals with fiscal years that match the Federal fiscal year would lose the amount of the budget neutrality adjustment from their HSP payments for all discharges during FY 1985. Hospitals with later fiscal years would lose revenues for only a portion of FY 1985.

Third, the reduction of HSP payment amounts due to the budget neutrality adjustment in FY85 would continue to apply to payments for discharges occurring in Federal FY86, after the budget neutrality requirement has expired. Just as payments based on HSP84 account for about 52 percent of total HSP payments in Federal FY85, a similar proportion of HSP payments in FY86 will be based on the HSP85 amounts and the second transition year blend factor (50 percent). These carryover HSP payments to hospitals with later fiscal years also would reflect the budget neutral adjustment factor (reduction) adopted in FY85. This reduction, however, would be roughly twice as large as the amount that would be needed if the adjustment applied to all FY85 discharges. Thus, the total amount of revenue lost over both FY85 and FY86 would be roughly double the amount actually required to achieve budget neutrality in FY85.

Analysis of Option 2

The second option would offset the whole 5.85 percent increase in aggregate payments under both the Federal portion and the hospital specific portion of the transition payment amount by an equivalent reduction in the DRG weighting factors for FY85. Since the DRG weights are applied in calculating the

payment rate for every discharge during FY85, this approach would be effective in reducing aggregate payments during the year. Again, however, the Administration has identified unfortunate side-effects.

As noted above, the HSP84 payment amounts (adjusted for budget neutrality), already reflect the 3.38 percent case mix adjustment applied in FY84. The 5.85 percent figure also includes the 3.38 percent. Since the DRG weights are applied in payment for all discharges, a full 5.85 percent reduction in the DRG weights would compound (double count) the reduction already included in the HSP84. Therefore, the actual reduction applied to HSP84 payments in FY85 would be over 9 percent instead of 5.85 percent. This would reduce aggregate HSP payments below the budget neutral level in Federal FY85.

In addition, hospitals would be penalized according to the beginning dates of their fiscal years. Hospitals with early fiscal years (beginning on or shortly after October 1) would lose very little revenue, while hospitals with late fiscal years could lose one percent or more of the PPS revenues otherwise payable during FY85.

Analysis of Option 3

The third option, adopted by the Department, splits the 5.85 percent adjustment into the 3.38 percent incorporated in each of the budget neutral factors and the 2.4 percent reduction of the DRG weights. According to the Administration, this option permits achievement of budget neutrality in FY 1985 without compounding the adjustment already reflected in the HSP84. It also minimizes the extent to which the rate reduction implicit in the budget neutral adjustment factor for HSP85 will carryover into FY 1986 when the budget neutrality provision no longer applies. Thus, in the Administration's view, it avoids the most serious disadvantages of the other options.

Senator DURENBERGER. The hearing will come to order.

First, my apologies to the witnesses and others in attendance for the little caucus of the Environment and Public Works Committee to decide what to do with Superfund.

Much concern has been expressed about the modifications that the Department and Health and Human Services has projected for the 1985 fiscal year payment structure of medicare's prospective payment system. The purpose of the hearing today is to examine and lay out for the record the Department's rationale for proposing these modifications and to shed light on the methodology used by the Department in setting the increase in DRG payments for fiscal 1985.

In 1983, Congress adopted this new payment system for hospital inpatient care under part A of medicare. The new system was designed to change incentives for hospitals by providing for a lump sum payment to these institutions per episode of illness rather than for payment based on the set of itemized costs incurred.

The new system encourages hospitals to offer services to medicare beneficiaries in a more cost-effective manner. It's not a perfect system, but the hospitals have accepted its challenge. It is a constructive first step in the reform of medicare. In adopting this reform, Congress sent a clear signal to the health industry as a whole, that the Federal Government will not continue to operate on a cost-based reimbursement system on its medicare services in the future. Instead, the Federal Government in its role as a prudent purchaser for its beneficiaries, will begin moving toward a payment mechanism for all medicare services based on the unit of an episode of illness. Beyond that, to a capitated system.

To successfully develop and implement those new payment mechanisms, however, both the hospitals and the other health care providers must be assured that the rules of the game for this system will be objective, realistic and consistent with public policy.

If health care providers cannot have confidence that the Federal policies will be true to these principles and the implementation thereof as true, there is a danger that the usefulness of the system will be undermined. To sustain this confidence and the momentum that has been achieved in the first year of the program, it is critically important that changes in the payment structure, such as we will discuss today, are made completely in the open, and that these changes are perceived as fair as well as perceived as meeting the requirements of the law.

In the future, the prospective payment system we have adopted for hospitals will reduce the cost of the medicare program to the medicare trust fund. The Congress, however, did not anticipate that savings would be achieved in the initial years of the new system. And, clearly, it did not want the transition to increase costs as new approaches sometimes do.

Therefore, the Congress directed that the aggregate payments for medicare under prospective payment should remain at the levels projected for the same services under prior law. The Congress additionally allowed in the legislation for a yearly increase in payment equal to the market basket of goods and services for hospitals, plus another 1 percent to compensate for technological advancement.

The hospital industry in America accepted these terms for the transitional period to full implementation of the prospective payment system in 1986. With that cooperation in mind and with that commitment by the providers to this new program, it is especially important that new payment structures designed to implement these provisions of the law do not make assumptions which may inappropriately hold down the overall funding level. To do this, the confidence of all health care providers in the new approaches might be threatened, as well as the long run success of converting the name in which medicare pays for all services.

Now the witness list for the hearing today is quite short. I'm pleased to see that. It is limited to the Department of Health and Human Services and the Administrator of the Health Care Financing Administration, Dr. Carolyne Davis. And it has done so not because the Chair of this subcommittee wishes to be exclusive of the opinions of others. It's done because we feel only the Department can provide the background on what it has proposed and why it has proposed to do it.

Testimony from others, much of which we have in hand, will be made part of that record. Anybody else that has additional testimony, it will be made part of the record.

It is the purpose of this hearing to put the Department on record in projecting modifications of the medicare payment structure.

I appreciate the willingness, the time, that the hospital industry has devoted to reviewing the changes proposed by the Department, and assure them that their concerns will be addressed in our discussions here today and in the future.

I look forward to a continuing dialog with the industry in this matter, and with other health care providers, dialog which may arise as we refine and improve the new payment system or medicare.

At this point, I would add only one other observation that occurred to me this morning when I was invited to participate in the middle of October back in Minnesota in an effort to have every member of Congress come and put themselves on the record on the issue. "Caution, this election may be hazardous to your health."

I don't happen to get much credit for my involvement in whatever reforms we are making in the health care delivery system. We catch all the heat for it, which is very appropriate in my case.

But the reality is that I often use the analogy that we are running a big insurance program here and we have a 535-member board of directors in this insurance company and only one or sometimes two show up for work. And it is a difficult process.

It is obviously made more difficult by the professional efforts of one generation, the generation of beneficiaries in this program, to politicize each and every act taken by this board of directors. Some of you are aware that I have a deep and unfortunately recent concern for generational equity in this country. And for the fact that we have perhaps delayed too long in making certain that all generations in the traditional sense has provided a better life for the next generation. And when I see things like the National Council of Senior Citizens and Lord knows who else combining in a major effort in the next couple of months to tell Congress that they cut medicare by $19 billion, cut the Federal portion of medicaid by $5.5

billion, that they reduced funding for community hospitals so drastically that hundreds have been forced to cut services or close their doors and that there will be meetings all over America, the bottom line of which will be get every club member out talking to the voters about who would be good and who would be bad on health issues, it bothers me at the insensitivity of my parents' generation, for my children.

So we will head here today into a discussion that I will not understand a great deal of because I am neither a mathematician or a formularian or an actuary or anything else. But I would suggest that the Department and the hospital administrators keep in mind the fact that the members of this board of directors of this insurance company can do something to help not only my parents' generation, but my childrens' generation, and you need to be sensitive to the things I said in that opening statement about fairness, equity. And maybe the law may read it this way, and that's the way we interpret it, but please try to keep our goals and our objectives and the reality of what we have to deal with here in mind as we go through this process.

So today we have our employees of the insurance company on the spot to tell us how they struggled with this major problem of how they made their 1983 decisions, and how they have felt they have had to make decisions in 1984 that relate to 1985. And I hope through this process that we will at least make a first record on what the Department feels is their obligation, and how far they have been able to take their opportunities to go beyond those obligations in the first 2 years of the system. And you must be sensitive to the fact that in fiscal 1986, you have got a free hand to do as you please with what has happened in America over the last few years in terms of changes in the way we deliver health care and the way we pay for it.

So with that, Carolyne, you may proceed. And as I have indicated, we have had a chance to visit, and we will have more opportunities, I hope, in the next couple of weeks before regulations come out. You may proceed to deliver your statement, illustrate it, whatever you will. And I have a long series of questions that I need to get on the record when you have concluded.

STATEMENT OF DR. CAROLYNE DAVIS, ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC, ACCOMPANIED BY PATRICE FEINSTEIN AND GUY KING

Dr. DAVIS. Thank you. I am very pleased to be here to discuss the proposed fiscal year 1985 prospective payment rate for our inpatient hospital services.

Accompanying me today is Patrice Feinstein, the Associate Administrator for Policy; and Guy King, who is the Chief Actuary and the Director of HCFA's Office of Financial and Actuarial Analysis.

As you have recognized, the medicare prospective payment system is, indeed, the single most important improvement since the program began in 1966. It replaced the cost based system, which truly did fail to encourage efficiencies in delivering service. We believe that by rewarding the efficiencies that the prospective payment system can be a potent weapon in our battle to control the

increase in health care costs. I think that the record to date indicates that the implementation phase of prospective payment has generally been an unqualified success. Clearly, there has been an immense cooperative effort between the hospital industry, the fiscal intermediaries and all other organizations to ensure a smooth transition into the new system. I think everybody needs to be recognized for their cooperative spirit in this particular activity.

I thought I would begin to talk about what, indeed, is a difficult and complicated subject—namely, how we determine the rates for the prospective payment system for fiscal year 1985—by a very, very brief review of the prospective payment system itself.

The prospective payment system is for medicare's inpatient hospital services only. I stress the fact it is inpatient only. It is based on diagnostic related groups and rates are adjusted by the regional wage index. We did indicate that those rates would be adjusted annually.

I would also like to mention that there is a medical education and a capital passthrough. Indeed, the capital passthrough increased this year, it looks like, approximately 20 percent. The additional payments outside of the rates themselves are recognized for a small number of atypical or outlier cases. And then certain types of hospitals are excluded, such as the pediatric and the long-term care hospitals. Prospective payment is determined as a form of incentive payment for hospitals with a prohibition against charging our beneficiaries. And one of our ultimate goals is to have a reduced cost reporting system. And, of course, during these first 2 years of implementation, we were charged statutorily to be budget neutral in the system.

Next chart please.

DRG's or the diagnosis related groups simply classify the patient into 468 different payment groups that are based upon the patient's diagnosis, their age, the treatment procedures that are done, the discharge status and the sex of the individual. In the regulations themselves—and I think you may have a copy of them—it lists 468 separate known DRG's that we determine with weights.

Let me give you a couple of examples. For example, DRG number one is a craneotomy or an operation on the head. That has a weight that is approximately 3.2762. Whereas, DRG-39, which is cataract extraction has a weighting system of 0.4893.

Now what that really means is that it is the relative amount of resources that are used to determine the care that is taken for a typical patient who has had cataract surgery versus the typical patient in the 1981 cost data who had a craniotomy. Obviously, a person who has brain surgery does need more care and uses more resources than somebody who has a simple cataract extraction. So the whole system of weights is based upon an index as against an index value of one.

Congress had indicated that we should phase into a national system, and indicated nine regional areas, using the census regions. Since we also establish separate urban and rural rates, we then in the first year had 18 separate rates for hospitals.

Additionally, this year we start to phasein the Federal piece. And so this year we actually have 20 separate rates that are published based upon the nine census regions, both rural and urban,

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and the two Federal rural and urban rates. This year's calculations will be based 50 percent on the hospital's own historical experience and 50 percent on this blend of the regional and Federal components.

To determine the actual payment per case to a hospital, let's take an example such as the appendectomy, DRG-164. This particular situation is in an urban hospital in New England. I'm sorry but my charts are a little old. They are last year's, but if you will just forgive me, I will follow through.

Let's say that 50 percent of the hospital's specific rate is calculated. The other part of the payment due would be the Federal rate composed of the blending of the regional and national rate. What the hospital determines then is what is actual per case amount would be without weighting. Once they know that by that blend of the hospital specific, and the Federal regional, they then take each individual case, look up the weight—for example, if it was the cataract or the craneotomy—in this case the DRG weight for 164, the appendectomy is 1.832. They take that weighting times the rate and that gives them that actual blended payment for that case. Because we are going to talk about both weights and rates, I thought it was important that we established those two particular areas.

Next.

The statute did indicate that we were to determine our factors for adjustments for 1985 and that the payments were to be for operating costs, and that those were to be adjusted to "be not greater nor less than" the payments that would have been made for those same activities under TEFRA. That we refer to as the concept of budget neutrality.

So that when we speak of budget neutrality, that's really what we are actually talking about.

The testimony itself gives detail to a number of the components that we talked about in relationship to some of the changes that we made in identification of rehab hospitals, transfer hospitals, urban and rural issues in census regions. But I think I would like to move more specifically to the other changes. And those are the changes that we refer to as the "rate system" itself.

Our proposed changes are to recognize and respond to those particular situations, following along with the constraints that Congress indicated that we should have—budget neutrality. Again, the rates are related to what we would have spent under the Tax Equity and Fiscal Responsibility Act.

The adjustments that we did make were to recognize the increases in the costs of goods and services used to provide inpatient hospital services, and we refer to that as the "market basket." And then we had to assure that the payments under that system would be no more than they would have been under the cost based system that had limits for 1985. We recognized that, under TEFRA, the cost per case limits would be moving downward to 110 percent this year. And that had to be calculated since those were the rules in effect prior to the prospective payment. That was part of our budget neutrality.

And we had some other adjustments that were reflective of changes in the phasing in of the hospitals, the impact of the transfers, and the proposed changes due to our regulation changes them-

selves. And then the reductions to the outlier payment from the 6 percent back to 5.

After we made those particular adjustments to the rates, we then made a determination that there should be an adjustment to the weights assigned to each of the 468 DRG's. In the data that we had initially published, we assumed that the complexity of the cases that would be treated, when we had better coding because the hospitals would be being paid under the diagnosis related group, would result in an increase of 3.38 percent. And when we established our rates in our fiscal year 1984, we had subtracted that particular 3.38 percent.

We indicated at that time that the actual experience in 1984 would be used to determine what our 1985 rates would be, and that if we felt that we needed to make a further adjustment, we would. And, indeed, on page 256 of the Federal Register on January 3, we clearly indicated with respest to the coding issue that, "However, based on actual experience we may change or replace the factor for the fiscal year 1985 determination." Our actual experience at the time that we published the proposed 1985 rates would indicate a significant increase in the case mix.

Senator DURENBERGER. Before you get to that, would you take a minute and explain the data base that was used to come up with the 3.38, and indicate whether or not the provider community was familiar with that data base and whether they had any objection to it at the time?

Dr. DAVIS. The data base that we used on the initial calculation of 3.38 was a comparison of data that we had received from the peer review, PSRO's, at that point in time. It indicated that there should be an adjustment approximately in the area of 3.38 percent. I think that that data was not questioned. When we published the interim final and then the final regulation, we had very few comments that related to that particular area. There seemed to be a general recognition that, indeed, better coding would result in an upward increase in the DRG's. The only comment that was raised was a question related to what would happen in the future. That's why we replied in the preamble to our January regulations that we thought we had estimated correctly, but obviously it was a sample, and that we would continue to track the actual outlays in the fiscal year 1984 and base our determinations for 1985 on those results.

In the 1985 proposal, we indicated that we had data from approximately 900,000 admissions, which would indicate the need for a further adjustment. That's why we did make a further adjustment in the neighborhood of 2.4 percent.

Since that point in time, we have had further admissions come in. We now have data from approximately 50 percent of all of the admissions that we expect under prospective payment in 1984 or roughly 2.5 million. That data continues to indicate even further upward movement in the DRG's. We will consider this additional data in developing our final notice. On the other hand, we are also hearing from the industry. And perhaps we can deal with their concerns later. So we have to weigh both of those factors.

The reason why we chose to reduce the individual DRG weights by the 2.4 percent was, I think, illustrated best by the impact on individual hospitals. If you reduced the weights across the board,

then at the beginning of the fiscal year each hospital has the same amount of reduction. If, however, we reduced the rates the impact varies because the individual hospitals come onto the system at different points in the year based upon their own cost reporting year. Let's take a look and see that for the hospital whose cost reporting year begins in October 1984, lowering the rates would have a heavier impact. It would be paying out more money throughout the entire year versus the hospital that doesn't come onboard until next July. And so we felt that it was simply more equitable that all hospitals should have reductions equally throughout the year versus having some hospitals—in effect, those coming onboard earlier in the year—subsidizing the hospitals with cost report periods beginning later in the fiscal year.

Senator DURENBERGER. Do I understand your testimony then to be that had we not phased it in by hospital fiscal year, that you would not have added or subtracted the realities of what you were planning out there from the weighting?

Dr. DAVIS. Yes; we would have taken it from the rate itself. The reason why we felt that it was more appropriate to lower the weights across the board is that we would have an equalization among all the hospitals by using it on the weighting system since the weights clearly impact across the whole year. It makes no difference what time of the year their cost reporting period starts because October 1 is when the weighting system would be factored in. So it would be equal across the year.

Our across-the-board reduction of the DRG weights is not a recalibration of the type that is required by law in 1986 and periodically thereafter. Recalibration is a change in individual DRG's that would recognize the change in the amount of resources that are used to treat a specific diagnosis. And that would be in relationship to all other diagnoses.

We think that the uniform reduction of all DRG weights simply does not change the relationships among the individual DRG's. Therefore, it is not a recalibration itself.

Let me say in closing that the Deficit Reduction Act of 1984 has been enacted since our NPRM and we clearly will need to make some changes which will be reflective of some of the provisions in the Deficit Reduction Act. We are analyzing those provisions and will make whatever adjustments are necessary to assure that the intent of that law is carried out.

And, in addition, we are analyzing the comments that we received from the July 3 NPRM. The estimation is we have about 3,500 comments in. Luckily, a number of them came in early and we have been working around the clock to analyze those. But we anticipate that the final notice, including any changes in the regulations that are required by the Deficit Reduction Act, will be published by September 1.

That is a brief summary in what I hope was an English summary version of our rationale for what we have accomplished. I would be happy to answer further questions.

Senator DURENBERGER. Thank you very much, Dr. Davis.

[The prepared written statement of Dr. Davis follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

CAROLYNE K. DAVIS, PH. D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

AUGUST 8, 1984

I AM PLEASED TO BE HERE TO DISCUSS THE PROPOSED FISCAL YEAR 1985 MEDICARE PROSPECTIVE PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES. ACCOMPANYING ME IS GUY KING, OUR CHIEF ACTUARY AND DIRECTOR OF THE HEALTH CARE FINANCING ADMINISTRATION'S OFFICE OF FINANCIAL AND ACTUARIAL ANALYSIS. THAT OFFICE WAS RESPONSIBLE FOR MAKING THE MATHEMATICAL CALCULATIONS NECESSARY TO ARRIVE AT THE RATES PUBLISHED IN THE FEDERAL REGISTER ON JULY 3, 1984 Page 27447(c)

AS THIS SUBCOMMITTEE WELL KNOWS, THE MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS) FOR HOSPITALS IS PROBABLY THE SINGLE MOST IMPORTANT IMPROVEMENT IN THE MEDICARE PROGRAM SINCE IT BEGAN IN 1966. FOR OVER 17 YEARS, HOSPITALS WERE REIMBURSED ON A REASONABLE COST BASIS WHICH FAILED TO ENCOURAGE EFFICIENCY SINCE WE REIMBURSED BASICALLY WHATEVER COSTS WERE INCURRED. UNDER PPS, WITH THE AMOUNT OF PAYMENT SET IN ADVANCE AND BASED ON THE PATIENT'S DIAGNOSIS, HOSPITALS WHICH ORGANIZE AND PROVIDE SERVICES IN AN EFFICIENT AND COST EFFECTIVE MANNER ARE REWARDED. OVER THE LONG RUN, PPS SHOULD PROVE TO BE A VALUABLE WEAPON IN OUR BATTLE TO CONTROL THE RISE IN HEALTH CARE COSTS.

THE SOCIAL SECURITY AMENDMENTS OF 1983 (P.L. 98-21), WHICH ESTABLISHED MEDICARE'S PROSPECTIVE PAYMENT SYSTEM, WERE ENACTED ON APRIL 20, 1983, LESS THAN SIX MONTHS BEFORE THE EFFECTIVE DATE. IN SPITE OF THE TIGHT TIME CONSTRAINTS, INTERIM REGULATIONS TO IMPLEMENT THE NEW SYSTEM WERE PUBLISHED ON

SEPTEMBER 1 WITH FINAL REGULATIONS PUBLISHED ON JANUARY 3, 1984. I AM HAPPY TO REPORT THAT, IN SPITE OF THE SHORT IMPLEMENTATION PERIOD, THE PPS SYSTEM IS FUNCTIONING SMOOTHLY AND HAS CAUSED MINIMAL DISRUPTION TO HOSPITALS. THIS SUCCESS IS A REAL TRIBUTE TO THE COOPERATION OF HOSPITALS, FISCAL INTERMEDIARIES AND OTHER ORGANIZATIONS WHO WORKED SO CLOSELY WITH US IN THIS EFFORT.

IN ACCORDANCE WITH THE LAW, THE PROSPECTIVE PAYMENT SYSTEM IS BEING PHASED IN OVER A THREE-YEAR PERIOD. DURING THIS PERIOD, A DECLINING PORTION OF THE TOTAL PROSPECTIVE PAYMENT RATE IS BASED ON A HOSPITAL'S HISTORICAL COSTS. THE FEDERAL PORTION, BASED ON A REGIONAL RATE THE FIRST YEAR AND A BLEND OF NATIONAL AND REGIONAL RATES IN THE SECOND AND THIRD YEARS, INCREASES EACH YEAR. BEGINNING WITH THE FOURTH YEAR (I.E., COST REPORTING PERIODS BEGINNING ON AND AFTER OCTOBER 1, 1986), THE MEDICARE PAYMENT FOR INPATIENT HOSPITAL SERVICES WILL BE DETERMINED FULLY UNDER A NATIONAL DIAGNOSIS RELATED GROUP (DRG) PAYMENT METHODOLOGY. FOR FISCAL YEAR 1985, THE SECOND YEAR OF THE PHASE-IN, WE HAVE DEVELOPED 20 FEDERAL RATES -- AN URBAN AND A RURAL RATE FOR EACH OF NINE CENSUS DIVISIONS AND FOR THE NATION AS A WHOLE.

PROPOSED CHANGES TO PPS

ON JULY 3, 1984, WE PUBLISHED A PROPOSED RULE WHICH WOULD MAKE SOME CHANGES IN THE PROSPECTIVE PAYMENT SYSTEM INCLUDING AN

ADDENDUM WHICH SETS FORTH THE PROPOSED RATES FOR FISCAL YEAR 1985. ALTHOUGH THE PROPOSED RATES ARE THE PRIMARY TOPIC OF THIS HEARING, I WOULD LIKE FIRST TO BRIEFLY SUMMARIZE SOME OF OUR PROPOSED CHANGES TO THE SYSTEM. WHILE THESE CHANGES WOULD NOT AFFECT THE TOTAL AMOUNT OF PAYMENTS TO BE MADE, THEY WILL AFFECT THE DISTRIBUTION OF PAYMENTS AMONG HOSPITALS. IN ORDER TO MAINTAIN BUDGET NEUTRALITY, WHICH I WILL DISCUSS IN GREATER DETAIL LATER, INCREASES IN PAYMENTS FOR HOSPITALS NEWLY ELIGIBLE FOR EXCEPTIONS, EXEMPTIONS OR OTHER ADJUSTMENTS WILL BE OFFSET BY DECREASES IN PAYMENTS TO OTHER HOSPITALS.

THESE PROPOSED CHANGES INCLUDE:

-- A REQUIREMENT THAT REHABILITATION UNITS HAVE A FULL-TIME MEDICAL DIRECTOR IN ORDER TO BE EXCLUDED FROM PPS WOULD BE RELAXED SO THAT A UNIT WITH SUCH A DIRECTOR PROVIDING SERVICES AT LEAST 20 HOURS PER WEEK WOULD NOW QUALIFY FOR EXCLUSION. ALSO, CRITERIA FOR EXPANDING REHABILITATION UNITS WOULD BE REVISED SO THAT HOSPITALS CAN MORE EASILY INCREASE THEIR CAPACITY.

-- CURRENT RULES WHICH ESTABLISH A UNIFORM DAILY PAYMENT FOR TRANSFERRING HOSPITALS WOULD BE MODIFIED TO PERMIT HOSPITALS WHICH INCUR EXTRAORDINARY COSTS FOR TREATING PATIENTS PRIOR TO TRANSFERRING THEM TO RECEIVE SPECIAL OUTLIER PAYMENTS.

-- CRITERIA FOR DESIGNATION AS A REGIONAL REFERRAL CENTER WOULD BE MODIFIED TO PERMIT ADDITIONAL HOSPITALS LOCATED IN RURAL AREAS TO QUALIFY. RURAL REFERRAL CENTERS WOULD RECEIVE THE HIGHER URBAN RATE.

-- CURRENTLY, HOSPITALS THAT ARE RECLASSIFIED FROM URBAN TO RURAL STATUS AS A RESULT OF OMB'S REDESIGNATION FROM METROPOLITAN STATISTICAL AREA (MSA) TO NON-MSA STATUS IMMEDIATELY RECEIVE THE LOWER RURAL RATE EFFECTIVE WITH THE BEGINNING OF THE NEXT FEDERAL FISCAL YEAR. TO AVOID ECONOMIC DISRUPTION, A TWO-YEAR PHASE-DOWN TO THE RURAL RATE WOULD BE PROVIDED.

-- SOME MSA BOUNDARIES CROSS MORE THAN ONE CENSUS REGION WITH THE RESULT THAT HOSPITALS IN THE SAME MSA RECEIVE DIFFERENT REGIONAL PAYMENT RATES. TO ASSURE UNIFORM RATES, AN ENTIRE MSA WOULD BE DEEMED TO BE IN THE CENSUS REGION IN WHICH MOST OF THE HOSPITALS IN THE CENSUS REGION ARE LOCATED.

Proposed Payment Rates and Total PPS Payments

WITH RESPECT TO DETERMINING THE INDIVIDUAL PAYMENT RATES, THE STATUTE GOES INTO SOME DETAIL IN SPECIFYING THE FACTORS TO BE USED IN DETERMINING RATES FOR FISCAL YEAR 1985. THE NEW RATES

WERE DEVELOPED IN ACCORDANCE WITH THOSE PROVISIONS. SINCE THE METHODOLOGY USED IN DEVELOPING THESE RATES IS DESCRIBED AT GREAT LENGTH IN THE FEDERAL REGISTER, I WON'T DISCUSS THE METHODOLOGY IN DETAIL HERE. INSTEAD, I WILL DISCUSS THE EFFECT ON PAYMENT INCREASE OF EACH OF THE ADJUSTMENTS. THE INDIVIDUAL FEDERAL REGIONAL RATES WILL INCREASE BY 5.6 PERCENT OVER 1984 RATES WHILE THE ACTUAL 1985 FEDERAL PPS PAYMENTS WILL INCREASE BY 6.6 PERCENT OVER THE PPS PAYMENTS ORIGINALLY PROJECTED FOR 1984.

I WOULD NOTE FURTHER, HOWEVER, THAT 2.4 PERCENT OF THE PROJECTED 6.6 PERCENT INCREASE REFLECTS AN INCREASE IN THE RECORDED COMPLEXITY OF MEDICAL CONDITIONS TREATED WHICH MUST BE ADJUSTED DOWNWARD TO REMAIN WITHIN BUDGET CONSTRAINTS. ADJUSTMENTS HAVE BEEN PROPOSED TO THE INDIVIDUAL DIAGNOSIS-RELATED GROUP WEIGHTS TO ACCOUNT FOR THAT INCREASE. THE ACTUAL OVERALL INCREASE IN FISCAL YEAR 1985 WILL BE 6.6 PERCENT MINUS 2.4 PERCENT OR ABOUT 4.2 PERCENT. THIS INCREASE IS APPROXIMATELY THE SAME AS ESTIMATED INCREASES IN GENERAL INFLATION DURING THE SAME PERIOD.

MARKET BASKET +1

FOR FISCAL YEAR 1985, THE MEDICARE LAW PROVIDES FOR AN INCREASE IN PROSPECTIVE PAYMENT RATES BY A PERCENTAGE EQUAL TO THE INCREASE IN THE COST OF THE MIX OF GOODS AND SERVICES USED TO

PROVIDE INPATIENT HOSPITAL SERVICES -- KNOWN AS THE MARKET BASKET -- PLUS ONE PERCENT. THE MARKET BASKET, BASED ON THE MOST RECENT DATA AVAILABLE, WAS DETERMINED TO BE 6.4 PERCENT. ACCORDINGLY, THE 1984 RATES WERE INCREASED UPWARD BY 7.4 PERCENT.

EFFECT OF TEFRA REQUIREMENTS

HOWEVER, THE LAW ALSO IMPOSES A FURTHER CONSTRAINT ON THE AGGREGATE PAYMENTS FOR INPATIENT HOSPITAL SERVICES DURING FISCAL YEAR 1985. PAYMENTS FOR OPERATING COSTS MUST BE ADJUSTED TO BE "NOT GREATER OR LESS THAN" PAYMENTS THAT WOULD HAVE BEEN MADE FOR THESE SERVICES UNDER THE STATUTE BEFORE IT WAS MODIFIED BY THE SOCIAL SECURITY AMENDMENTS OF 1983. THIS CONCEPT HAS BECOME KNOWN AS "BUDGET NEUTRALITY."

PRIOR TO THE ENACTMENT OF THE SOCIAL SECURITY AMENDMENTS OF 1983, A SYSTEM OF LIMITS ON INPATIENT OPERATING COSTS PER CASE AND TARGET PERCENTAGE INCREASES HAD BEEN ESTABLISHED BY THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT (TEFRA), P.L. 97-248. THESE PROVISIONS RESTRAINED INCREASES IN OVERALL PAYMENTS FOR INPATIENT HOSPITAL SERVICES IN FISCAL YEARS 1983 THROUGH 1985. ALLOWABLE COSTS PER CASE WERE LIMITED TO NO MORE THAN 120 PERCENT OF THE AVERAGE FOR SIMILAR HOSPITALS IN 1983, LOWERED TO 115 PERCENT IN 1984 AND 110 PERCENT IN 1985.

SEPARATE TARGET RATES WERE ALSO ESTABLISHED WITH BONUSES FOR HOSPITALS WITH COSTS LESS THAN THE TARGET AND PENALTIES FOR THOSE WITH COSTS THAT EXCEED THE TARGET. IN 1983 AND 1984, HOSPITALS WHOSE COSTS EXCEEDED THE TARGET RATE WERE REIMBURSED 25 PERCENT OF THE EXCESS. THIS 25 PERCENT PAYMENT WAS ELIMINATED FOR FISCAL YEAR 1985. THIS CHANGE, WHEN COMBINED WITH THE REDUCTION IN TOTAL COSTS PER CASE LIMITS, SUBSTANTIALLY RESTRAINED INCREASES IN PROJECTED TOTAL EXPENDITURES UNDER TEFRA RULES IN FISCAL YEAR 1985. WE THEREFORE PROPOSED TO REDUCE THE RATES BY 2.1 PERCENT TO REMAIN WITHIN THE TEFRA LIMITS.

EFFECT OF PHASING ONTO PPS

DURING FISCAL YEAR 1984, HOSPITALS WERE COMING INTO THE PPS SYSTEM AT THE BEGINNING OF THEIR COST REPORTING YEAR. IN GENERAL, HOSPITALS WHICH ENTERED THE SYSTEM EARLY IN THE YEAR WERE LOCATED IN AREAS WITH LOWER WAGE LEVELS AND LOWER REGIONAL RATES AND THEY HAD LOWER INDIRECT TEACHING COSTS THAN THOSE WHICH ENTERED LATER IN THE YEAR. THE INCREASED IMPACT OF THE TEFRA LIMITS IN 1985, WHEN ALL HOSPITALS ARE SUBJECT TO THE RATES FOR THE ENTIRE YEAR, LED TO A PROPOSED DECREASE OF .4 PERCENT IN THE PROPOSED RATES. EVEN WITH THIS DECREASE IN THE FEDERAL RATE, HOWEVER, INCREASES IN THE FACTORS MENTIONED ABOVE WILL INCREASE THE AVERAGE PPS AMOUNT PAYABLE PER CASE BY .8 PERCENT.

ADJUSTMENT FOR TRANSFERS

IN ESTABLISHING RATES FOR FISCAL YEAR 1984, WE HAD NO DATA OR EXPERIENCE TO MEASURE THE IMPACT OF OUR PROVISIONS ON PAYMENT FOR TRANSFERS. UPON ANALYZING ACTUAL EXPERIENCE, WE HAVE DETERMINED THAT THE PAYMENT PROVISIONS FOR TRANSFERS REDUCE OVERALL AVERAGE REIMBURSEMENT BY .5 PERCENT. THEREFORE, WE PROPOSED INCREASING THE 1985 RATES BY .5 PERCENT.

CHANGES IN REGULATIONS

THE PROPOSED CHANGES IN THE REGULATIONS WHICH I DISCUSSED EARLIER NECESSITATED ADJUSTMENTS TO THE FEDERAL RATES. THESE REGULATORY CHANGES -- PRIMARILY THE DESIGNATION OF RURAL REFERRAL CENTERS -- WOULD REDUCE THE RATES BY .7 PERCENT.

CHANGES IN OUTLIER CRITERIA

BEFORE SETTING THE FISCAL YEAR 1984 RATES, TOTAL ESTIMATED PAYMENTS WERE REDUCED BY 6 PERCENT TO ACCOUNT FOR OUTLIER PAYMENTS. OUTLIERS ARE EXTRA PAYMENTS IN INDIVIDUAL CASES WHERE THE LENGTH OF STAY OR COSTS OF PROVIDING SERVICES ARE MUCH HIGHER THAN AVERAGE. WE HAVE DECIDED TO ALLOCATE A HIGHER PERCENTAGE OF PAYMENTS TO TYPICAL CASES AND A LESSER PERCENTAGE TO OUTLIER

PAYMENTS. THEREFORE, FOR 1985, WE HAVE DETERMINED THAT 5 PERCENT OF TOTAL PAYMENTS SHOULD BE SUFFICIENT TO REIMBURSE OUTLIERS. ACCORDINGLY, THE PROPOSED RATES WERE INCREASED BY 1 PERCENT.

ADJUSTMENT TO DRG WEIGHTS

AS I PREVIOUSLY NOTED, IN ADDITION TO RATE ADJUSTMENTS, WE HAVE REDUCED THE WEIGHTS ACCORDED TO EACH OF THE 468 DRGs. AS YOU KNOW, THE ADJUSTED, ESTABLISHED RATES ARE MULTIPLIED BY THE DRG WEIGHTS TO ARRIVE AT THE AMOUNT OF PAYMENT FOR THAT DIAGNOSIS. THE WEIGHTS ARE ASSIGNED IN ACCORDANCE WITH THE COMPLEXITY OF TREATING ON INDIVIDUAL DIAGNOSIS AS COMPARED TO ALL OTHER DIAGNOSES. IN ESTABLISHING THE 1984 RATES, WE ANTICIPATED THAT THE COMPLEXITY OF THE MIX OF INDIVIDUAL DIAGNOSES (THAT IS, CASE MIX) TREATED IN 1981 (THE BEST DATA AVAILABLE AT THAT TIME) WOULD INCREASE BY 3.38 PERCENT IN 1984.

ACTUAL EXPERIENCE IN FISCAL YEAR 1984, HOWEVER, HAS INDICATED THAT HOSPITALS ARE TREATING A LARGER NUMBER OF HIGHER COST CASES THAN HAD BEEN PREDICTED. A SUBSTANTIAL PORTION OF THESE INCREASES MAY BE DUE TO BETTER CODING OF DIAGNOSES AS A RESULT OF THE DRG SYSTEM. HOWEVER, FISCAL YEAR 1984 DATA AVAILABLE AT THE TIME THE PROPOSED RATES WERE DEVELOPED INDICATED THAT THE ACTUAL CASE MIX INCREASE WAS 5.85. WE EXPECT THIS ELEVATED LEVEL TO CONTINUE THROUGH FISCAL YEAR 1985.

PAYMENTS FOR THIS INCREASED LEVEL OF CASE MIX MUST CONTINUE TO BE CONSTRAINED BY THE LIMITS OF BUDGET NEUTRALITY. THEREFORE, WE WOULD BE REQUIRED TO REDUCE PAYMENTS TO HOSPITALS BY 2.4 PERCENT IN 1985. TO ACCOMPLISH THIS REDUCTION, WE CHOSE TO DECREASE THE INDIVIDUAL DRG WEIGHTS BY 2.4 PERCENT AT THE BEGINNING OF THE YEAR.

A MAJOR BENEFIT OF RECOGNIZING THE OBSERVED INCREASE IN CASE MIX THROUGH AN ADJUSTMENT TO THE DRG WEIGHTS RATHER THAN THE RATES IS THAT REDUCING PAYMENT IN THIS MANNER IS MORE EQUITABLE TO THOSE HOSPITALS WITH COST REPORTING PERIODS BEGINNING EARLY IN THE FEDERAL FISCAL YEAR. (MOST HOSPITAL COST REPORTING PERIODS DO NOT COINCIDE WITH THE FEDERAL FISCAL YEAR.) THE ADJUSTMENT TO COMPENSATE FOR AVERAGE GROWTH IN CASE MIX WOULD TAKE EFFECT ON OCTOBER 1, 1984 RATHER THAN BEING PHASED IN THROUGH THE BUDGET NEUTRALITY ADJUSTMENT OF THE HOSPITAL-SPECIFIC PORTION. BY REDUCING THE DRG WEIGHTS AND THE RESULTING PAYMENT AMOUNTS AT THE BEGINNING OF THE FEDERAL FISCAL YEAR, RATHER THAN WITH EACH HOSPITAL COST REPORTING YEAR, HOSPITALS WITH COST REPORTING PERIODS BEGINNING EARLIER IN THE FEDERAL FISCAL YEAR WOULD NOT HAVE TO SUBSIDIZE THOSE HOSPITALS WITH COST REPORTING PERIODS BEGINNING LATER IN THE FEDERAL FISCAL YEAR.

I MUST EMPHASIZE THAT THIS CHANGE IN THE DRG WEIGHTS IS NOT A RECALIBRATION AS CALLED FOR IN THE LAW IN FISCAL YEAR 1986 AND PERIODICALLY THEREAFTER. RECALIBRATION IS A PROCESS BY WHICH

WEIGHTS OF INDIVIDUAL DRGS ARE REVISED TO REFLECT A CHANGE IN THE RESOURCE CONSUMPTION OF THAT DIAGNOSIS RELATIVE TO OTHER DIAGNOSES. OUR PROPOSED ACROSS-THE-BOARD ADJUSTMENT DOES NOT CHANGE THE RELATIONSHIP AMONG INDIVIDUAL RATES.

WE HAD NOTED IN OUR DISCUSSION PRECEDING THE FINAL REGULATION PUBLISHED ON JANUARY 3 THAT ACTUAL EXPERIENCE IN 1984 MIGHT NECESSITATE A CORRECTION IN 1985 OF THE CASE MIX ASSUMPTION USED IN 1984.

Cost-Related Payments

THE ADJUSTMENTS I HAVE JUST DESCRIBED RELATE TO PAYMENTS MADE UNDER PPS. HOSPITALS WILL CONTINUE TO RECEIVE PAYMENT ON A COST BASIS FOR CAPITAL-RELATED COSTS AND DIRECT COSTS RELATED TO APPROVED MEDICAL EDUCATION ACTIVITIES IN HOSPITALS WHICH HAVE TEACHING PROGRAMS. THE COST-BASED PAYMENTS ARE EXPECTED TO RISE BY A MUCH LARGER PERCENT THAN THE PROJECTED PPS INCREASES. FOR EXAMPLE, CAPITAL COSTS PER ADMISSION ARE CURRENTLY INCREASING IN EXCESS OF 20 PERCENT PER YEAR.

MR. CHAIRMAN AND SUBCOMMITTEE MEMBERS, AS THE FOREGOING DISCUSSION OF THE IMPACT OF MEDICARE'S PROPOSED PROSPECTIVE PAYMENT RATES FOR FISCAL YEAR 1985 INDICATES, THE STATUTORY

REQUIREMENTS ARE QUITE SPECIFIC. WE HAVE USED THE MOST RELIABLE DATA AVAILABLE IN ESTIMATING THE AMOUNTS THAT WOULD HAVE BEEN PAYABLE HAD THE PREVIOUS TEFRA LIMITS REMAINED IN EFFECT IN ORDER TO ARRIVE AT BUDGET NEUTRALITY.

DEFICIT REDUCTION ACT OF 1984

I HAVE DESCRIBED THE IMPACT OF THE ADJUSTMENTS TO THE PROSPECTIVE PAYMENT RATES FOR FISCAL YEAR 1985 WHICH WERE PROPOSED IN A NOTICE IN THE FEDERAL REGISTER ON JULY 3. SINCE THAT DATE, THE DEFICIT REDUCTION ACT OF 1984 (PL 98-369) HAS BEEN ENACTED WHICH MAKES SOME CHANGES IN THE PROSPECTIVE PAYMENT SYSTEM WHICH MAY AFFECT THE FINAL RATES. WE ARE CURRENTLY ANALYZING THOSE PROVISIONS AND WILL MAKE WHATEVER ADJUSTMENTS MAY BE NECESSARY TO ASSURE THAT THE INTENT OF THE LAW IS CARRIED OUT. IN ADDITION, WE ARE OF COURSE ANALYZING THE LARGE NUMBER OF COMMENTS RECEIVED ON THE JULY 3 PROPOSED RULE AND ADDENDUM.

WE ANTICIPATE THAT THE FINAL NOTICE AND ANY CHANGES IN THE REGULATIONS REQUIRED BY P.L. 98-369 WILL BE PUBLISHED BY SEPTEMBER 1.

I WILL BE GLAD TO ANSWER THE SUBCOMMITTEE'S QUESTIONS AT THIS TIME.

39-884 O - 84 - 4

FY 1984 - 85 CHANGE IN FEDERAL PPS RATES

Adjustments	Percent Change	Example: New England Urban Rate
FY 1984 Rate	---	$2,967
Market Basket + 1	+7.4	+220
Effect of TEFRA requirements	-2.1	-66
Effect of phasing onto PPS	-0.4	-13
Adjustment for transfers	+0.5	+16
Changes in outlier criteria	+1.0	+32
FY 1985 Rate	+5.6	$3,134

FY 1984 - 85 CHANGE IN PROJECTED AVERAGE FEDERAL PPS PAYMENTS PER CASE

Adjustments	Percent Change
FY 1984 Average Payment	---
Market basket + 1	+7.4
Effect of TEFRA requirements	-2.1
Effect of phasing onto PPS	+0.8
Adjustments for Transfers	+0.5
FY 1985 Gross Average Payment	+6.6
Adjustment for Case-Mix Complexity	-2.4
FY 1985 Net Average Payment	+4.2

Senator DURENBERGER. In the Deficit Reduction Act—the conferees also said, "recognizing that budget neutrality will be a primary consideration in the establishment of the fiscal year 1985 hospital payment rates, conferees are nevertheless concerned about the perception that they may be unfair and inequitable. The conferees realize that the appropriateness of the new levels of payment will be vital to the success of the full implementation of the prospective payment system. The conferees urge the Secretary to carefully evaluate the potential impact of the proposed rates on the long-term success of the prospective payment system." And I'm sure you are doing that anyway, but I just wanted to read that part for the record. And I will ask you a couple of questions about the issue of budget neutrality.

The first is a general question. If you would, tell us what it is that we must compare for purposes of budget neutrality? Is it estimated aggregate outlays for hospital inpatient services under TEFRA as compared to estimated aggregate outlays under PPS or what is it?

Dr. DAVIS. Actually, it is a comparison between the operating payments under TEFRA and those under the prospective payment system. We have to keep in mind that there are some pass-throughs, and while we have to count those, we also have to separate them out because the comparison is between the inpatient operating costs.

For example, the medical education and the capital are pass-throughs. So while they are looked at the budget neutrality estimation is on inpatient operating costs.

Senator DURENBERGER. Just explain to me in language I can understand how the medical education and all the rest of these things are excluded to get down to the operating.

Dr. DAVIS. I think this is a little more complicated and I'm going to ask Guy King if he will do that.

Mr. KING. The ratio that applies to the operating payment applies only to the operating payment and not to total payments. In other words, once we have stripped away all the complications of the phasing in and so forth, what is basically required is a comparison of the estimated payments, operating payments, under PPS with the estimated operating payments that would have been payable under TEFRA. Whatever the difference is, a ratio has to be applied to the operating payments under PPS to equalize it to the operating payments under TEFRA.

The only reason that the passthrough costs enter into this formulation at all is that the passthrough costs under TEFRA and the passthrough costs under PPS are slightly different.

Senator DURENBERGER. I don't want you to try to explain it to me because I won't understand it, but is that difficult process? I mean if you just showed everybody in this room that are more knowledgeable than I how that is computed, would everybody understand it and agree with it? Is it relatively simple?

Mr. KING. Well, I mean——

Senator DURENBERGER. I mean to pull out the operating.

Mr. KING. An oversimplified comparison is simple, but to actually go through how we took account of the phasing in of the Federal rate system compared to the hospital specific rates, and then the

phasing in of the national payment rates as opposed to the regional rates, and the phasing in of the hospital specific piece by provider fiscal year versus the Federal payments becoming effective immediately on October 1, that is a very complex explanation to give. We have met with the hospital industry twice, and I gave a presentation to the State financial people explaining to them exactly how——

Senator DURENBERGER. But just determining the outward bounds of operating expenses, as you call them, for purposes of budget neutrality during the prior law versus current law, is that a difficult explanation?

Mr. KING. No, it's not terribly difficult based on the 1981 cost report data. We separated the operating payments from the pass-throughs.

Senator DURENBERGER. And maybe you can add a little bit to the record on the assumptions that are used in estimating hospital payments under TEFRA versus those used to compute aggregate payments under prospective payment systems. Where might some of the assumptions differ if they differ at all?

Mr. KING. The assumptions are really precisely the same. The key assumptions that we used in the determination of TEFRA payments are the estimated increase in cost per admission and the hospital market basket. And the assumptions that we used under TEFRA are what we think would have happened under TEFRA. Actually they are somewhat more liberal than what is currently happening, what the current trends in the hospital industry show.

Senator DURENBERGER. Can you make a record for us today on what your pre-PPS estimates would have been as to the number of admissions by DRG category under the old law versus the number of admissions that you estimated under the new law and that actually took place under the new law? You didn't mention admission rates.

Mr. KING. As we pointed out in the 1984 regulations, we assumed that there were no differences in admission rates under PPS and under TEFRA. It was a simplifying assumption that I felt had validity. Therefore, admissions dropped out of the formula completely and the comparison is really done on a per admission basis, which is appropriate since PPS has a payment per admission, and TEFRA limits were on a per admission basis.

Senator DURENBERGER. I may have missed something, but did I hear you to say that you didn't think there would be any difference in the number of admissions during this period of time?

Mr. KING. Yes, sir. No difference in incentives for increasing admissions between PPS and TEFRA.

Senator DURENBERGER. And that if we had never heard of PPS's and DRG's and all these acronyms would the admission that you estimate in 1983—that the admission rates would increase or decrease or do you have any of those figures available to us?

Mr. KING. Yes; of course, prior to the advent of prospective payment, we didn't have to make projections of admissions. We had to make projections of days. What we saw initially after the beginning of prospective payment was that in 1983 admissions began to increase enormously over what the long-term trend had been. We did not make any adjustments in the 1984 PPS rate for this. Had

we made the assumption that the increase in admissions was due to the incentives of PPS, we would have been required to make a downward adjustment in the payment rates in 1984. We did not make such an adjustment.

Likewise, toward the end of 1983 and in early 1984, the number of admissions relative to what was happening in 1983 has dropped off. When you compare admissions in 1984 with 1983 levels, they have actually declined. But they haven't declined relative to 1982 levels. In other words, 1983 appears to have been a blip that is offset by a downward blip in 1984.

Senator DURENBERGER. I read some testimony here last night that said there has been a gradual decline. And from the graph that I have just been presented from April 1982 through April 1984, that is certainly true in under age 65 admissions. And it indicates that there was a slight increase in the early part of 1983 in overage 65 admissions. And than what looks to me like sort of a leveling off. Does that coincide with your judgment on admissions?

Mr. KING. Yes. If you are looking at the graph provided by the American Hospital Association—I have looked at the same graph and that compares fairly well with what we are seeing in the medicare program.

Senator DURENBERGER. I don't know whose I'm looking at at—and since this isn't a court room I don't have to be that precise, I guess. [Laughter.]

If I look at the second chart of whosever this is, it's entitled "Length of Stay, Seasonally Adjusted." You are probably familiar with what I am getting at.

Mr. KING. Yes.

Senator DURENBERGER. The underage 65 lengths of stay appears from April of 1982 to April of 1984 to be sort of a very small decline from 5.9 days to like 5.65 days. However, in the category age 65 and over length of stay there has been a decrease in that same period of time like from 10.15 all the way down to approximately 9.1. Does that conform with the information that you have available?

Mr. KING. Yes, sir.

Senator DURENBERGER. And did you know in the 1983 period of time that that was going on and likely to be taking place out there?

Mr. KING. Yes. Length of stay began declining in 1983. We were aware of that in 1983, before the advent of PPS.

Senator DURENBERGER. Did you attribute at that time either the admissions performance, if you will, and the length of stay to anything in particular for purposes of planning for the implementation of the PPS system?

Mr. KING. No, we did not. If you could look at a graph of the longer period of time, you would see that admissions fluctuate up and down unpredictably. Sometimes we find out after the fact why they went up. We may find out that weather conditions or particularly bad flu seasons or something like that caused an increase in admissions. We usually find out about it after the fact. Sometimes even after the fact we can't discover what the reasons for the change in admissions are.

Senator DURENBERGER. I assume Guy spends a lot of his time looking into a computer whereas you, Carol, or somebody else has to actually—and I'm not denigrating you, Guy.

Mr. KING. That's all right, sir. [Laughter.]

Senator DURENBERGER. That somebody else has to deal with the reality of what might be happening. And, again, my question is to try to explore what I will call behavorial changes that you would have or could have predicted would take place if we were moving into a definite commitment to a prospective payment system, and if nobody had ever breathed the word and we were back on the old TEFRA cost base reimbursement system. Maybe you want to tell me something about what you actually did know about behavorial changes that could be attributed to the prospective and so forth, and how you dealt with that in arriving at your assumptions.

Dr. DAVIS. Well, I think it's very clear that the initial work in TEFRA where we moved to a cost per case limit had a significant impact on system changes because for the first time the limits were on a per case rather than a per day basis. We clearly began to see some dramatic reductions in length of stay. We anticipated that that would continue. And, indeed, our monthly monitoring would indicate that that is true. So I think that reductions in length of stay really began once we put limits on a per case basis and that trend has simply continued.

Likewise, we recognized initially that when we moved to payment per admission there was a possibility that individual institutions might, game the system and we might see some increases in admissions. That's why we developed our admissions pattern monitoring system. In point of truth, we have not seen that. It looks like this year's admission pattern will be about one-half of 1 percent less than what we had expected it was going to be. So I think that we recognize that the system didn't actually lead to any perverse behaviors on the part of the hospitals at all.

I think there are other factors outside of prospective payment. For example the more we move to encourage the use of outpatient facilities for ambulatory surgery and for a number of other activities that are appropriate to be treated outside of the hospital, then the more we can expect to see that admissions would be dropping in recognition of that factor. So over the long term one would anticipate some continued reduction in the admissions profile.

Senator DURENBERGER. You have mentioned this in your testimony, but would you be likely under an episodic approach to see early changes in resource utilization as well? If you went back in American medical history—and I can't do this—but if we had had this in place 10 years ago, do you think the craneotomy would have been 3.2 or would it have been 5.2 or something else or would the cataracts have been 0.4 or was the technology for cataract extraction less refined and required more resources? The whole point being here is that you testified that that recalibration doesn't come until 1986. I'm trying to get you to make a little record here about the things that you anticipated actually happening out there in 1984 and 1985 because of the change in that.

Dr. DAVIS. Right. It's mostly from anecdotal evidence. From talking with individual hospital administrator: we recognize that they have gone into some very aggressive internal monitoring to do

their own medical review of activities. And they are looking at a variety of measures such as trying to examine whether or not they need certain laboratory tests, whether or not they need to have as many procedures done as they have been in the habit of using in the past in the area of ancillary testing—x rays and lab tests and things of that nature. So we know there is an aggressive campaign to decrease some of that particular activity. Given the fact that there is a variety of practice patterns—as has been testified to by Winburg and others—there can be reductions that don't impact on the quality of care.

Senator DURENBERGER. One of the things I quoted earlier from, this Viller's Advocacy Associates, put your politicians feet to the fire and that was to reduce funding for community hospitals so drastically that hundreds have been forced to cut services or close their doors. Now I take it the reality is that over a period of recent time changes have been taking place in America's 7,500 hospitals. But is it also a reality that the knowledge that we are going to prospective payment system and the reality of it has caused some major changes in where hospital services are being purchased in America? In other words, my recent little trip through the rural part of Minnesota found this, without examining it further, to be true. I mean they hadn't closed but they were all broke. If they hadn't had some generous city taxpayers trying to hang into their hospitals the way they hang onto their hospitals, they would have been out of business.

But what was happening wasn't a decrease in the quality of health care or hospital care for people in those communities. They were ending up in different hospitals. Now to what degree is that sort of change and its impact on hospital case mix and so forth—to what degree did you take that into consideration in making your assumption?

Dr. DAVIS. We don't have any actual data that would relate to how many hospitals have actually moved to close out certain services and/or expand other services, although anecdotal evidence would indicate that some of that is clearly occurring. And I think that is appropriate to have happen because clearly hospitals that are being paid now under the DRG system recognize that the volume of procedures that they do has an impact on their costs. Another area of concern is very high cost, high technology procedures such as open heart surgery—it seems like every hospital had begun to go into the business of open heart surgery with particular emphasis on coronary artery bypass surgery. Even if they were doing only one a month, it was rather a prestige factor to be able to say they had these services. And I think that a number of those types of institutions have now begun to look at that activity and have deduced that the volume is not there and it's impractical from that point of view. Particularly, if there is another nearby hospital in the community doing five or six of these a week, the hospital with few procedures can decide that it's more appropriate that the nearby hospital specialize in that procedure and it won't handle that particular activity.

So we know anecdotally that there is beginning to be some of that occurring, but we do not have data in hand that relates to that.

Senator DURENBERGER. I understand you don't have the data in hand, but would you acknowledge in your professional judgment that the medicare system and its trust fund in particular has and will in the future substantially benefit from whatever—I don't want to use your words exactly because I can't remember them—from everybody going into the heart business and everybody going into the hip business. Is that not a predictable benefit from this new system.

Dr. DAVIS. I think we are going to have exceptionally good benefits for the quality of care, and I think that's a very important thing to remember. And that is that we know from the study that has been done and the Public Health Service recently published that looked at a number of high technology procedures the study found that where they are done in an institution that has a larger volume, they have a team that is prepared at all times; they recognize complicating factors early and can intervene; and they have a higher success rate and less mortality. So we believe that by some consolidation of these kinds of high technology activities we will actually improve the quality of care.

Now it also follows that some of those institutions which have ceased doing certain high technology procedures made that judgment not only, I'm sure, out of the quality of care aspect but perhaps out of their concern for the cost relationships too. But I think this is a case of where prudence and management actually have an outcome that is higher quality care.

Senator DURENBERGER. But if this new system improves quality of care, reduces cost to medicare, then the reality is that it might cost us a little money in the near term to make that happen. It seems to me that has been the whole theory. And just because I show up at these meetings doesn't mean I'm qualified to be on the board of directors. So include myself in the 535 who when we say budget neutrality—we always do that in a budget context.

But I guess I have always felt that we were going to have to spend a little money in order to make a little money or to save a little money in this system. And so I take it you don't argue the point that in the long run that we have just been talking about now will improve quality and reduce the overall cost.

Dr. DAVIS. I would absolutely agree, sir. I think I'm puzzled a little by why we would be spending more money because in general price times volume equals a lower price because of the volume that you get. And if one assumes that you are consolidating into larger facilities where they are doing more of these procedures then it strikes me that assuming our rates are fair and we believe they are, then I'm not clear——

Senator DURENBERGER. You are in my judgment at least, making a 1986 argument. And I am here dealing with why you have done what you did in 1984 and 1985 when in effect I said to you we might have to spend a little money in order to make a little money. So I think that's the point.

I totally agree with the conclusions you have come to. That's the way this marketplace can work best. And the more demand, the more efficient you get, the more you can do to improve the quality and reduce the cost. But I understood very clearly as a participant

in this process that that's what we would ask the Secretary to do for fiscal 1986 with regard to reflecting all these things.

What we are doing here today is trying to figure out why you are coming to those conclusions a little bit early by reducing the reimbursement by 2.2 percent.

Dr. DAVIS. I think you are relating to the case mix index and why we made a decision to reduce that. I would like to speak to that particular issue.

We had anticipated, based upon our sample study, that better coding would occur when the hospital was getting paid under the system of DRG's versus before when it didn't make as much of an impact on them fiscally. And we knew from our study that there would be that improvement. We had recognized that by last year taking a factor of 3.38 into consideration and clearly said, "This is based upon sample. We will look next year at the actual behavior and determine whether or not we need to make any further adjustments."

In looking at our data for what we had this year we rated that the increase was greater than we had projected. Admittedly, when we came out with the July regulation, we had only 900,000 cases. We have now been able to get 2.5 million cases. And it still shows that continued upward trend.

Two things that I would like to observe. One is that it seems to be that that upward trend occurs only in the first 2 months after a hospital comes into the system and thereafter it levels off. Second, we compared hospitals that were on the system with those hospitals that were in States that did not have prospective payment—namely, our waivered States—because one would assume the general behavior patterns would be the same across all. If, indeed, it was due to factors of the patients aging or greater intensity of services, those would be across all States. That pattern was not the same. The States that did not have a prospective system under DRG's did not have a case mix index increase. And so we concluded—that seemed to us to indicate that the majority of that increase had to be attributed to better coding, and that we needed to correct for that.

Senator DURENBERGER. I mean you are now at the heart of it, and I'm probably going to try to get to it at my own pace rather than your's here with my questions. I think we are at the heart of the matter, so to speak. And I have been asking you behavioral questions and you are saying that we told you "we will look at behavior," but you are concluding that you did that because you knew that your information was less than accurate; not that you were predicating this year's changes on actual changes in behavior due to the prospective payment system.

Dr. DAVIS. That is correct. What I am saying is last year when we made the initial adjustment, we made our best judgment at that point based upon a sample, and clearly said in the January regulation, "If this isn't right, we will revisit this." And so we need to revisit that.

Senator DURENBERGER. Obviously, my problem with that is that your information is coming back to you at the same time that we send out the PPS so it is very, very difficult for either of us to be right. You can argue that it was predictable misinformation that is

now good information and here comes the higher case mix, and I can argue, in effect, that information would not have come back to you had there not been a requirement under the PPS system that it come back. But when it came back it was influenced in part—and I say this with not necessarily endorsing everything they have to say—but in part because the hospital industry in this country had a major stake in making this system work. We can argue that on a hospital by hospital basis, but it strikes me that the people who have the most to gain by making the system work is the American hospital industry. Again, I'm not espousing their cause or I don't know how they did this, but I would assume that they went to a fair amount of effort within the industry to try to, provide you with a lot of really great information and now they are of the opinion that that information is being used against them. And you are saying, "well, we told you so. We told you in 1983 that we were going to use this against you in 1984."

So that's why I don't have them here today. I don't want to make them look stupid. [Laughter.]

Dr. DAVIS. The data we gathered was from actual activity in terms of our monitoring of the system; that we had indicated we would do the first year.

Senator DURENBERGER. Not stupid, gullible.

Dr. DAVIS. So I think that came from our fiscal intermediaries. I think we have to make some very careful judgments between how much of this actually is due to an increase that we should have expected from the coding and how much of it is due to the potential increases that the hospital industry has indicated they believe it is—mainly that the patients are sicker.

Clearly, I'm quite sure that some of their comments in the replies to our NPRM should be addressing this particular area; indeed, they seem to be. So we are hopeful of looking at all of that and studying both of these and coming out with some kind of a careful balance.

Senator DURENBERGER. We are not going to resolve this here today. I am going to ask you some more definitional questions, but let me also ask you to make a record for us on a couple of other things. Practically all of the hospital industry testimony that we have here indicates that you do not have, or the Secretary does not have, legal authority to adjust DRG weights until 1986. What is your lawyer's response to that one?

Dr. DAVIS. We would not have sent out the proposed regulation if we believed it weren't legal, so clearly our lawyers believed that we were. I think, again, I would relate that it is not a recalibration when you do an across-the-board reduction. And our other choice would be to go back and to use the DRG rates, which we think has some inequities and unduly penalizes some hospitals as opposed to other hospitals. Those hospitals that would be going on early in the year would be, in effect, subsidizing the other hospitals. But we certainly could go back to doing it that way.

Senator DURENBERGER. Let me ask you another question which is for the record. And I will quote in part from the record testimony of the American Hospital Association dated August 2, 1984, in the form of a letter to you.

The adjustments to the 1985 prices purportedly comply with the first of these requirements. That is that in 1984 and 1985 the price would be set at a level that would result in aggregate payments neither greater than nor less than the aggregate payments would have been under continuation of the cost per case limits under TEFRA. While HCFA officials have met several times with hospital representatives, it has never been made available to either hospitals or the public the detailed documentation of the studies or data used to establish both the fiscal 1984 or fiscal 1985 prices. Among the most important of these studies are those used in the comparison of 1981 MEDPAR and PSRO hospital discharge data, the estimates of FICA reentry costs, the adjustments to 1984-85 prices for outlier payments, the setting of outlier thesholds, justification of the randomization method used in the TEFRA simulation model to project actual costs per case for individual hospitals, and the estimates of the impact of the change in transfer policies and other policy changes on the fiscal year 1985 prices.

Jack says more than that, but the point of the question is to indicate what it is that prevents you from making some or all of that information available to the affected industry.

Dr. DAVIS. Well, let me reply to that in two ways. No. 1, we have tried to be as open as we possibly could be. Last year, the industry did request the 1981 MEDPAR files and hospital identification was removed so that we have a public use file for that. Likewise, the 1981 cost report file. Those are the two principal files that we have used in the development of the DRG's and the determination of the budget neutrality.

Now it is a public use file because of certain identifiers that we felt would lead back to identification of individuals. And under the Freedom of Information Act, we simply feel we have to protect that kind of an individual activity.

I would also like to point out that Mr. King has met twice in open sessions with whomever wished to show up with data runs, with whatever kind of material that we had there. And I wasn't present, but I understand that we had a fair sized group of people from the hospital industry that did come. He was there, I think, for 4 hours on 2 separate days with Q&A time. So it seems like we have been as open as we feel we could be.

Senator DURENBERGER. Is there no way that patient names and characteristics could be removed from MEDPAR files to preserve confidentiality?

Dr. DAVIS. We created a public use file. And I think I'm not allowed to say anything more about that at this point in time under advice of my general counsel since the industry is suing us on this particular issue.

Senator DURENBERGER. Let me ask you some questions on case mix changes. Hospital representatives have argued that average intensity has been increasing for years, even before TEFRA and PPS. Do you believe this general trend has continued? In other words, have you analyzed the changes in coding from 1981 to 1984 to determine what part of the increase was in fact a result of increased intensity as opposed to improved accuracy in coding? Does the adjustment as proposed offset the effect of this general trend and should it?

Dr. DAVIS. I'm going to ask Mr. King if he will describe more in detail what we have done in terms of our analysis of this. Again, keep in mind that we have tracked this through from 1981 to 1984 and compared those States that were under prospective payment using DRG's versus those that weren't. The fact is that in those

that weren't we did not see an increase in case mix. And in all other ones, we did see an increase in case mix. It makes us pause and wonder what is going on in terms of that particular activity.

Senator DURENBERGER. I think I have an answer for that.

Mr. KING. Based on all the evidence that we have examined, Senator, the evidence is circumstantial but it suggests overwhelmingly that virtually all of the increase in case mix that we have observed from the 1981 MEDPAR data is just an increase in coding. Having said that, I will say further that even if it is a real increase in case mix, the adjustment should still be made because this a comparison between the payment per admission under prospective payment and the payment per admission under TEFRA.

The factors that we have used to update the TEFRA limits already reflect the increases—any increases that might have occurred in case mix—because of case mix increases; then that will have a tendency to increase the cost per admission. And the cost per admission trends that we use have the trends in increased costs built into them.

Having said that, I will go into the reasons why we feel so strongly that the increase in case mix is just a function of the reporting system and not a real increase in case mix.

First of all, we examined the data from 1979 to 1981.

Senator DURENBERGER. Are you backing up to 1983?

Mr. KING. Yes.

Senator DURENBERGER. Keep to your chronology too as you go through this because this is an important part.

Mr. KING. When we were setting the prospective payment rates for 1984, we had contemplated that if there are any increases in case mix, whether it be due to aging of the population or just secular trends in case mix, they ought to be taken into account because that would push up the PPS, payment per admission, and therefore the comparison with the TEFRA payment per admission. It should be taken into account.

What we found in examining the case mix data from 1979 to 1981 is that there was no increase in case mix from 1979 to 1981.

Senator DURENBERGER. That there was what?

Mr. KING. There was no increase in case mix from 1979 to 1981. We also have the ability to make projections of what the increase in case mix would be based on the aging of the population. In order to do that, we constructed an age-sex specific DRG case mix index. Then we applied that case mix index to our population projections. And what we discovered, once again, is that over a short period of 3 or 4 or 5 years the increase in the overall case mix index due to the aging of the population is virtually negligible. The only reason it has any significance is because we have to make 75-year projections. And on a cumulative basis, aging of the population over a 25-year period might increase the case mix index by 3 or 4 percent. But over a 3- or 4-year period, it's just about negligible.

Senator DURENBERGER. So 1979 to 1981 you saw no change?

Mr. KING. That's right. As Dr. Davis pointed out, we examined the increase in case mix in the non-DRG States—Maryland, Massachusetts, and New York—and we compared the 1981 case mix index with the 1984 case mix index based on the data that we have

through July of this year and we found out that in every State, in every one of those States, the case mix index dropped slightly.

Senator DURENBERGER. How comparable is the 1984 data in the way that it is reported from Maryland, Massachusetts and New York to the data that is reported in the nonwaiver States?

Mr. KING. It's reported in the same way.

Senator DURENBERGER. And for how long a period of time has it been reported in these waiver States in that way?

Mr. KING. For the same period of time that we have had data reported.

Senator DURENBERGER. Everybody has been reporting?

Mr. KING. The patient data has to go through what is called a "grouper program," which takes the data and assigns the DRG to the patient bill. And it's done the same way in the waiver States as it's done in the nonwaiver States.

I might point out that in doing this comparison from 1979 to 1981 the data was based on the MEDPAR grouper, which was used to set the prospective payment rates. There is a slight bias between the MEDPAR grouper and the full grouper that we have now, which is a little more detailed. This bias amounts to around 1 percent. In other words, for example, of the 7.3 percent increase in case mix that we have observed since 1981, the MEDPAR grouper program would have captured all but about 1 percent of that.

I guess one other piece of evidence that we have seen that there is not a real increase in case mix is that if there were a real increasing case mix of the magnitude that we are seeing, 7.3 percent, then what we would be observing was a continuing trend from October when PPS first began up until July. And we haven't seen that.

What we have seen is that when a hospital goes on PPS its case mix increases and then it levels out at that level.

Senator DURENBERGER. I hate to keep going back to the admissions but I guess we have agreed that there is a presumption that utilization by service has changed somewhat in hospitals in this country in the 1980's.

If the numbers of the admissions to many hospitals decreased, might it be likely that the intensity of the admissions in those hospitals will probably increase? Is that normal behavior?

Mr. KING. Yes. We would expect that to happen. If the admissions had declined, we would expect that the case mix index for the number of admissions that remained as inpatient hospital admissions, would increase. If, in fact, that is going on, then once again what that would imply is that as case mix increases because of that fact, the cost for those admissions would increase and the cost per admission in that hospital would increase. So once again those factors have been built into our determination of the average payment per admission under TEFRA.

Senator DURENBERGER. Again, I'm coming to this because that isn't just a coding mistake. That's just a part of the reality of what is going on.

Mr. KING. Yes.

Senator DURENBERGER. Right?

Mr. KING. Yes. And what I am saying is that we have already captured it in the trends that we use to update the prospective payment rates and the cost per admission under TEFRA.

Senator DURENBERGER. Carolyne, your reference now to the waiver States requires me to ask a question. I know you have been very sensitive to what some of these States are doing, but would you describe for me the difference in the incentives in Maryland, Massachusetts, and New York as it affects all the hospitals in those States versus the incentives under PPS and the rest of the country? I mean it strikes me that those that want all hospitals to survive go the Maryland, Massachusetts, New York route until somebody can decide which ones they want to let go and which ones they don't want to let go. Whereas in the rest of the country, a different kind of a system is determining so-called winners and losers.

But before jumping to conclusions about what Maryland, Massachusetts, and New York will tell us by comparison, it strikes me that there is a fairly substantial different set of market kinds of incentives that operate in those three States from the rest of the country.

Dr. DAVIS. Well, indeed, each system in each one of those States is somewhat different than prospective payment using the DRG's. I think that their overall goal is to contain their rate of growth just as one of our overall goals is to restrain the rate of growth. And I think the fair comparison would be to give you a detailed analysis of the complex factors that make each one of those systems different. Each one of those is entirely different from the other. And we can provide for the record what those factors are and then what our estimate is of what their increase and their rate of growth has been vis-a-vis what the general rate of increase has been. Right now we are out doing audits in each of those States so that we will have an audit base to be able to determine what we would have been paying in that State if we had been under the DRG system. And then we will be able to compare that to what their actual expenditures are. And that material we will have in later this year. But for the record I will submit a detailed analysis of the differences between the States.

Senator DURENBERGER. That would help.

[The information from Dr. Davis follows:]

CASE MIX INCENTIVES IN MARYLAND, MASSACHUSETTS, AND NEW YORK

The hospital rate setting programs which operate in Maryland, Massachusetts, and New York each lead to a different set of incentives. Some of these incentives were purposely created by the program developers, but others were indirectly created in attempts to correct for other factors.

The basic framework for the Medicare prospective payment system (PPS) is the diagnosis related group (DRG) classification system. Establishing a price for each DRG creates a strong incentive to treat each type of case more efficiently. Moreover, establishing the payment level with a blend of hospital-specific, regional, and national price levels now and using national norms once the system is fully in place will strongly reinforce those efficiency incentives. The decision not to adjust Medicare payment levels because of volume changes is another strong reinforcement of the pricing principles used by Medicare to establish a fixed prospective reasonable price for each type of case.

Under PPS, the financial implications of a hospital's coding practices is very apparent. There are extremely strong incentives and direct and immediate financial rewards associated with careful attention to any secondary diagnoses and procedures which might place a patient in a higher priced DRG. In fact, hospitals now

are able to balance the cost of computer software packages or extra medical coding specialists against the extra revenue which may be generated due to claims which are coded into more complex and presumably more accurate DRG categories.

It is certainly to be expected that the financial importance of coding under PPS would bring quick reactions from the hospital industry. The result of such action would be an immediate increase in case mix as measured by DRGs. It is also to be expected that if the reaction is swift, the increase in case mix would also taper off just as quickly, since there is only limited room for such improvement.

The Maryland, Massachusetts, and New York systems started with different frameworks. The basic purpose of each system was to control the increase in total hospital costs. They were primarily interested in total cost control and only secondarily interested in causing major system changes. The incentives created by these systems do not differ significantly from the incentives in Medicare under TEFRA prior to PPS. Under TEFRA, Medicare placed a total limit on cost per case which was adjusted for case mix using a DRG case mix index. However, the incentives for major changes, other than strict cost control, were not apparent in the Medicare system under TEFRA. Hospitals had little reason to concentrate strictly on the coding of cases particularly if their costs were below the total cost per case limits. In the case of hospital below the limit, the major concern is limiting increases in costs. Hospitals above the limit would be inclined to view the case mix limit not strictly as an efficiency problem of the hospital but instead as a Medicare tool for cutting costs by penalizing hospitals.

The three State programs likewise use case mix primarily as control methods. The overall case mix of a hospital is used to restrict increases in revenue, to adjust costs before applying penalties, or it may be used simply as a mechanism for appeals when a hospital believes it can justify added expenses.

MARYLAND

The Maryland program concentrates on setting a revenue level for each hospital which the Health Services Cost Review Commission believes is sufficient to assure the financial solvency of an efficiently run hospital. Their review program by law is operated on an individual hospital basis. There are several basic features to the Maryland system:

An individual budget review performed for each hospital in a base year,

Rates set by department, such as revenue per day or per lab test,

Inflation increases announced periodically. If the hospital accepts the announced rate of increase, the new rates are essentially automatic. If the hospital needs a higher increase, it can request a budget review,

A Guaranteed Inpatient Revenue system which controls the rate of increase in a hospital's total cost on a per case basis. A hospital may increase its volume of ancillary tests, but the increase in total revenues per case as measured by DRGs or other case mix measures may not increase more than a prescribed amount, and

All increases in revenues due to changes in volume are adjusted so that the hospital receives only a part of the extra revenue to cover its marginal costs.

The primary incentive created by the system is to operate within the guaranteed inflation increases rather than to undergo a complete budget review. Prior to the Guaranteed Inpatient Revenue system, there was also an incentive to increase ancillary testing to generate more revenue.

In the Maryland system case mix is used as a control mechanism. The case mix incentives created by the system are not as apparent as those in PPS. Certainly a hospital that actually increases its case mix or one that increases its case mix by improving its coding will be authorized to generate more revenue. However, the revenue is only generated in the aggregate. For each patient it is paid on an itemized charge basis and not because of the specific diagnostic codes on each bill. A hospital can easily ignore case mix provided it keeps the increase in its costs under control and does not increase ancillary testing any more than may be due to changes in the types of cases it treats.

Case mix is only used to review an individual hospital's own mix from year to year. There are no automatic comparisons of case costs between hospitals in the system. If any comparisons arise, they would likely be for added information during a budget review.

The use of case mix was gradually introduced into the Maryland system. The collection of patient abstract data was initiated several years ago for all patients. While some improvements in the coding of claims should have been anticipated over the past several years, no sudden changes in coding practice should be expected as a result of the Maryland payment system.

MASSACHUSETTS

In Massachusetts, Medicare agreed with the Massachusetts Hospital Association to pay hospitals based on the Blue Cross contract. This program is in the strictest sense a rate of increase control program which guarantees status quo for all hospitals but also requires each to meet restrictions on their total revenues.

The contract calls for a base year to be fixed for each hospital which will serve as the cost basis for payments to each hospital for 3 years. Increases are prescribed by contract for volume changes and expected intensity increases. There are no direct adjustments for case mix changes. The legislation which mandated the demonstration for all hospitals also required that all payers be offered a 2 percent productivity adjustment each year for 3 years and a 1 percent per year adjustment for 2 more years. The productivity adjustment is a direct percentage reduction in base year costs for each hospital.

The Massachusetts system has one overriding incentive, i.e., to hold the line on increases from the status quo as well as a general belt tightening caused by the productivity adjustments. There are other more subtle incentives created by the specific volume adjustments in the system particularly for ancillary tests, but these are secondary.

Hospitals are rewarded for lowering their costs regardless of how their costs compare in other hospitals, and these rewards carry forward into each year of the demonstration.

There is no immediate conclusion on how case mix changes would affect a hospital's revenues. The revenue impact will depend on other factors such as the total change in ancillary use, the overall volume of cases in the hospital, length-of-stay changes, etc.

Given the above discussion, there is no reason to expect that hospitals would have had any reasons to improve their coding accuracy or to change their case complexity in response to the system.

NEW YORK

In New York, there is a long history under their cost control program. Many of the more significant improvements in the New York system over the past few years have been in the area of case mix.

These case mix improvements were prompted by a large backlog of case mix appeals in their rate setting system. Technical changes were then introduced to directly compare case mix adjusted costs as part of the rate setting process. By 1982, most of New York's case mix developmental work had been completed, and they incorporated into their per diem payment system nearly every cost control factor which might be associated with case mix.

The current New York program which Medicare joined in 1983 has the following features:

A base year, 1981, is fixed for each hospital for 3 years.

Routine cost per day for each hospital is compared to a routine cost per day limit for similar hospitals after adjusting for case mix and standard length-of-stays. The hospital has the lower amount approved as its base.

Ancillary cost per admission for each hospital is compared to ancillary cost per admission for similar hospitals after adjusting for case mix. Again, the hospital has approved the lower amount as its ancillary base which is then converted to a per diem.

The hospital's total approved base cost per day is then projected to the prospective year based on a trend or inflation factor and adjustments are made for volume.

The New York system clearly creates incentives to treat cases more efficiently by lowering length-of-stays, reducing unnecessary tests, and by lowering any other operational costs which may be possible.

However, even with all the case mix adjustments incorporated in the system, the New York program retains the perception as a per diem system. As a result, all of the up front incentives attributed to a diagnoses specific payment system are not usually attributed to the New York program. The hidden case mix features of the system do not seem to encourage major change but instead give the appearance of just another penalty scheme. A hospital does not automatically receive higher revenue for treating a more complex case. Hospitals only receive a fraction of their cost per admission for each additional case. If a hospital's overall case mix changes substantially, the hospital may file an appeal. In summary, case mix is primarily a technical adjustment factor in the New York system, rather than the driving force of the system.

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There is no reason to expect any sudden changes in the case mixes of hospitals in New York. The gradual introduction of case mix as a factor in the New York system should have led to some enhancement in the hospitals' coding practices, but no abrupt changes in their practice should have occurred.

SUMMARY

Neither the Maryland, Massachusetts, nor New York systems create the strong positive incentives which exist under PPS to treat each type of case more efficiently. Their incentives relating to case mix are at best negative incentives. Their systems are oriented primarily towards rate of increase controls, and case mix is used primarily as a technical adjustment. PPS is oriented primarily towards inducing change in a hospital's behavior. The case mix payment system allows for cost control features to be incorporated in a positive way. Hospitals and their medical staffs now have strong incentives to treat each case as efficiently as possible. However, because the rewards are also directly related to the coding of the claim, there are strong incentives not associated with the State systems to be as accurate as possible in DRG coding under PPS.

Senator DURENBERGER. Now let me ask you about this whole business of case mix and the 896,000 cases which you had to use. Those were the cases that you had to use initially. They are up now to 3 or 4 million. Is that correct?

Dr. DAVIS. 2.5 million as of July 21, which was our cutoff date.

Senator DURENBERGER. I wonder if you would describe for us what your concerns might be relative to the legitimacy of your current sample. In other words, you have excluded already certain kinds of hospitals by law. Are you getting an accurate estimate by geographic region, by type and size? You must have some little concern about the accuracy of your sample, and maybe you would share those concerns with us.

Dr. DAVIS. Our sample now is based on approximately 50 percent of all of the claims or the admissions that we had projected for this year. We think that's a fairly representative sample. It is true that we also have stood back and looked at the geographic differences by census regions as related to whether or not there was any difference that we could detect there. We could not detect any substantial differences between the census regions, although we have some feeling—and it has been expressed—that many of the hospitals that come on in July will be your larger hospitals. But we think there is a representative sample within the other areas; particularly, since we have gone back and looked at the various census regions. However, we will take that into consideration in our final determinations of how we balance out the case weights versus the intensity of services.

Senator DURENBERGER. Your statement indicates that the 2.4-percent weight reduction was a requirement of budget neutrality. Why wasn't it presented as such in the proposed regulations?

Dr. DAVIS. We believe that it was presented as a part of that. I think you may be referring to why we chose to take it on the weights versus using it in the rates. And, again, I would go back to our feeling that by adjusting it across-the-board, the weighting system meant for more equity across all of the hospitals. By taking the adjustment on the rate itself, then that rate becomes effective when the hospital's fiscal year begins. And you have an unevenness with the hospitals that come on early in effect subsidizing those hospitals that come on later. We felt that wasn't as fair, and

therefore chose to do an across the board adjustment, which we then applied against the weights themselves.

Senator DURENBERGER. Do you plan to compare medical records of 1981 and 1984 as opposed to billing and claim forms to determine whether case mix has changed at any point in time in the future?

Dr. DAVIS. I do not believe that we have any ability to go back and do that. The medical review records from 1981, I suspect, would be difficult for us to obtain at this point in time although we have talked about how to get better comparison data between the various years so that we could have even more confidence than we now do.

Senator DURENBERGER. What other options do you have?

Dr. DAVIS. Well, at this point in time we are still exploring any possible options. I'm looking forward to the compilation of the comments that we have received as it relates to case mix index so that we can find out if the industry itself has any data that they have submitted or any options that they can think of that they have commented on. And we will take those into serious consideration as we make our final determinations.

Senator DURENBERGER. What effect will your deflation of the DRG weights have on fiscal year 1986 payments when budget neutrality is no longer a consideration? Will the weights, for example, be increased by 2.4 percent for 1986?

Dr. DAVIS. No, I wouldn't expect that they would be, but it would be difficult for me to say at this point what we would be doing in 1986. But if you think about the fact that if our adjustment is purely related to the fact that it is better coding, then it seems what we would be doing is a one time adjustment to correct for that factor.

But I couldn't indicate what the 1986 year will bring. We clearly in 1986 will be doing a very significant amount of recalibration; looking at the amount of resources that are allocated for each DRG, individual DRG by DRG. So we have to wait the outcome of all of that before we can predict what 1986 will look like.

Senator DURENBERGER. With regard to recalibration in 1986, do you have any current concerns about the resources available to you either informational resources or financial resources to adequately base the recalibration that you would be required to make? Do you expect also to revisit the case mix issue each year as we go along?

Dr. DAVIS. Well, I think clearly our qualifications for recalibration mean that we should use the best data that we have available. Now we could use 1982 cost data. On the other hand, there is other data available—such as our MEDPAR files. I mean there is a variety of options. What we want to use is the best data that we can. Clearly, we would like to use data that is most relevant to prospective payments, meaning data that we have available that would show us what has been going on within prospective payment itself. So we feel confident that we have an array of data by which we can make those comparisons. It will give us some confidence in our recalibration system.

Senator DURENBERGER. Just so I understand it, going back to my old question about the craneotomy and the cataract extraction and so forth, you have presently, coming in, all of the kinds of informa-

tion you need on resource utilization to help you make recalibrations?

Dr. DAVIS. We believe that we will have all of that in-house. Yes, sir. I would also like to point out that the Prospective Payment Assessment Commission is also charged with looking at some of the data that relates to technology improvements and to the recalibration. And I know that they have been focusing on one or two of the areas, as we have also, as it relates to changes in technology. And we have occasionally gone out and asked a specific group to give us more data as it relates to one or another of the specific DRG's. For example, if it's cataracts, we ask the American Academy of Opthalmology. If it's something to do with hip replacements, we would ask the orthopedic surgeons group. So we have occasionally asked for data that relates to new technology and how that would impact upon DRGs. We will take that into consideration as we move to recalibrate next year.

Senator DURENBERGER. Is there a point in time when you have so much information that the computer blows up in Guy's face? It's just sort of useless having this stuff coming in year after year after year. I mean there is this current cost reporting requirement. Is it a good requirement? We only require you to keep it for a year. Do you feel you ought to keep it longer? Do you feel that we ought to continue to require that kind of information to come in?

Dr. DAVIS. We are trying to streamline that cost report just as much as we can, sir. Keep in mind that there are some parts of it that are needed because of the passthroughs we must have. Until we move the medical education and the capital and until we move all parts onto this system, we still have need of a cost report for outpatient costs, for these other passthroughs. We hope to streamline it just as much as possible. And, of course, our eventual goal would be to do away with that. And we think that's possible because we could eventually use a sample or we could use other techniques.

So I think the final answer is that we have sufficient data streams coming in. Obviously, if we didn't have the computerization capacity to track these activities and to merge them, we would be overwhelmed with the data. And our computer capacity, I think, is going to be stretched in the near future, but we have sufficient capacity at this moment.

Senator DURENBERGER. It's only the really hot days that you have problems. The preamble to the proposed rule indicates that you have encountered severe data problems in connection with the development of a new wage index, but that you may solve these problems in time to publish a new index in the final regulation. The Deficit Reduction Act established a deadline of August 17 for the Secretary to report to Congress on this matter. Parenthetically, every hospital in my State is waiting for you to digest their information and meet that deadline.

What is the status of this issue? And will you be publishing a new wage index quite soon and when?

Dr. DAVIS. Well, clearly, our problem has been that not all of the hospitals gave us the requested data the first time that we went out. Some of that was due to confusion between themselves and

their intermediaries and some of it was simply due to the fact that the data either wasn't available or they didn't choose to submit it.

We have gone back out again and asked for additional input. Unhappily, we still don't have all the data in-house. We are trying desperately to get it all in. The problem is that if you don't have complete data sets, then you are deriving the index from an incomplete data base. And when we did that, using the data that we had had initially, hoping to get it out in the NPRM, we had very significant swings in the reductions or additions to the wage mixes. As much as $800 per case. We felt that was greatly abberant in terms of what we could use and it would be bad to substitute 1 year's bad data collection for another year's bad data collection. So we have to get the system with all data in-house before we can come out and publish that.

I'm doubtful whether we are going to make it in time for the final regulation. We may. I simply can't say yet. We are working aggressively in this area. But I would like to point out that that is a retrospectivity in terms of the adjustment. I believe that under the Deficit Reduction Act, Congress did indicate that when we do get that out, we should apply it retroactively. So we will continue to work aggressively on it.

Senator DURENBERGER. Well, let me just make the observation that that is probably the No. 1 issue in my State, and I do give them the explanation about retroactivity. And I think that for the most part, depending on what your final judgment is, that they would agree with your theory. That it is better to do it right than to replace bad data with bad data. And I don't envy you the task because we have tremendously complicated this with this NSA system.

The current PPS regulations state that if the Secretary fails to publish new final rates by September 1, the old rates continue in effect for the following year. I assume you want to assure this committee that new rates will be published no later than September 1.

Dr. DAVIS. Absolutely. There will be no vacations for anybody inside HCFA if we thought we couldn't reach that date. We believe that we are on track and we will be.

Senator DURENBERGER. The definition of "rural referral center" in the proposed rule focuses on case mix as the key criteria. Under the Deficit Reduction Act a major detriment is specified to be operating characteristics. Will there be any change in the final regulation to reflect the factors listed in the new legislation?

Dr. DAVIS. It's too soon for me to say just yet. We clearly, under the NPRM, indicated five different areas that we thought were operational factors that would identify rural referral centers. We asked for comments from the industry on that. That has been one of our long-ranging discussions. And it's only by meeting with various groups that believed that they were rural referral centers that we could even come to some agreements initially as to what we thought those were. We published those and clearly asked for comments, and we are reviewing those comments. And we will value the comments. But I think it's pretty clear that we believe that to be a regional referral center one ought to look different than a general rural hospital, which means you have to have some special op-

erating characteristics. We have identified some of those. And we will wait to see with comments from the industry how closely——

Senator DURENBERGER. Let me ask that question just slightly differently. You know very well that Dan Quayle and the rest of us put this amendment together rather hurriedly. As you have worked at trying to comply with the requirements of the Deficit Reduction Act, are you running into some problems that we might be able to help you with by way of defining what we meant as opposed to having to relegislate?

Dr. DAVIS. I think our staffs have worked fairly closely on this particular issue. To my knowledge, I don't believe we have found any particular problems. It's true that to be identified as one, one has to have certain operational characteristics. And if somebody doesn't fall into that and they believe that they clearly are, then there is a problem. On the other hand, there are some hospitals in rural areas who don't like others being designated as regional referral centers, and so we hear both sides of that issue as we do on most issues.

Senator DURENBERGER. One other observation. There seems to be some disincentives showing up in the prospective payment system which I would guess you would like to address. We certainly would. And I will give you one example. And that is that hospitals may no longer do bilaterial procedures because the payment for bilateral procedure is no greater than that for a unilateral procedure. And as a result, there is every incentive to split what could otherwise be one admission into two. What do you expect can be done to correct that kind of disincentive?

Dr. DAVIS. We don't have any actual evidence of that, although we have heard anecdotally that it is occurring.

Senator DURENBERGER. This is my point. These docs don't want to do that, but you push them to the wall and they will because the system seems to tell them that's what you ought to do. They don't want to do it because they care about their patients.

Dr. DAVIS. I think part of our problem is to try to determine whether or not that was recognized when we did the initial calculations. And we are trying to go back and look at that factor. Let me use the example of the bilateral hip replacement.

We have to go back and look at our 1981 data base and find out what percentage, if any at all, were included at that point in time, and whether there has been a change in trend since that point in time. Clearly, if the cost of doing two was recognized there and trended forward, then we don't have a problem.

On the other hand, we could aggressively monitor the system to make sure under our peer review systems that the medical review cites those occasions when it has been inappropriately split and done as a second procedure. Alternatively, we have to look if those costs weren't there initially—then what should we appropriately do? It may well be that this is a reclassification issue. There may be times when we might find that we need to recognize that for a single hip replacement you have a DRG weighting of X and for a double hip replacement you have weighting of Y.

The few occasions that we have heard about, we are now studying and trying to collect that data. Recently we have talked with the orthopedic surgeons group. They don't have the data either, but

they are going to try to help us to see if we can get some data that relates to that area.

Senator DURENBERGER. I guess with enough frequency so that the staff is telling me not to do it, I have said it is more important to do the 93 percent of PPS right than it is to find an answer to the 7 percent, that is, the capital. And they have told me to shut up. And you have earlier an hour or two ago confirmed the reason why I ought to shut up by indicating that the capital passthrough has increased by 20 percent.

Dr. DAVIS. That's correct.

Senator DURENBERGER. Can you give us similar figures on the other passthroughs, that is, medical education? Could you give us some indication of what the increases might be on the pediatrics, long-term care, so we can compare that with what everybody is else is getting?

Dr. DAVIS. We will probably submit most of that for the record, but I will ask Mr. King if he would speak to that. I would point out that it's difficult for us to compare the increases on the medical education because under law Congress doubled the indirect expenditures as the proxy for the severity of illness. So we have to take that factor into consideration when you try to compare the medical education costs. In relationship to what is going on in the nonprospective payment hospitals, we have been tracking that fairly carefully and accurately, and I don't believe there has been a significant change in that. But I will ask Mr. King to speak from his recollection. And then we will submit some things for the record.

Mr. KING. The 20-percent increase in capital payments was really based on data submitted and published monthly by the American Hospital Association. Their data doesn't break down the other passthroughs, so we don't have the latest trends in the other passthroughs.

Senator DURENBERGER. Could you develop some information with regard to these for us over the next couple of months?

Mr. KING. Yes, it's a little slower in coming in because it has got to be reported through the intermediaries. That's why we have the interest and depreciation reported from the AHA.

Dr. DAVIS. In relationship to the other hospitals, we do have, under our tracking system, some data that shows some trends. It's quite aggregate, for example, in terms of long-term care, the skilled nursing facility, home health, and some of those kinds of expenditures. They seem to be coming in appropriately. And we are also tracking the non-PPS hospital part, so we will provide what we have up to date on that area.

Senator DURENBERGER. All right.

Let me just in closing make an observation. There was an interesting story in the paper last week or maybe a couple of weeks ago about my junior colleague who had to be traced down out at National Airport to come back and vote to give away $5 billion in Social Security. And I'm glad they were able to find him and bring him back. And it was probably the longest rollcall on record so that 87 of us could stand up and give away money we don't have.

On this side, I won't argue with the data base. We have been cutting away at the medicare budget. And I just want to close on a positive note that I think we are doing things right here—all of us,

all of the people who have come here today—to deal with a very difficult issue. I think we are on the right track. And it strikes me that it is important to the elderly in this country and to their kids that in the next couple of weeks, we try to continue the openness on the part of the administration that we have seen here today. And let's see if there isn't some way that we can accommodate that statement in the Deficit Reduction Act about where we want to be and what you believe to be not only the requirements of the law but also the existing realities.

So while we all go off on vacation on August 10, Friday, I will certainly keep myself available to participate in this process. We don't get a lot done at these hearings other than to stimulate the meetings and sometimes form concensus. And I hope that this is one of those times when we can stimulate a concensus. So I appreciate, Carolyne, your openness. And, Guy, your help. And, Patrice, it was just great having you down here for the last couple of hours.

And the hearing is adjourned.

[Whereupon, at 11:49 a.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

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TESTIMONY OF

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CHAIRMAN, NATIONAL AFFAIRS COMMITTEE

OF THE

AMERICAN COLLEGE OF GASTROENTEROLOGY

BEFORE THE

COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
UNITED STATES SENATE

CONCERNING

ADJUSTMENTS IN MEDICARE
PROSPECTIVE PAYMENT SYSTEM

ON

AUGUST 8, 1984

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present the views of the American College of Gastroenterology concerning recent final rules proposed by the Health Care Financing Administration to adjust and reduce the relative weight of each DRG category for fiscal year 1985.

The membership of the American College of Gastroenterology is comprised mostly of practicing physicians, who see patients daily in our offices and hospitals. Our primary concern is for the patients we serve. Optimum care and quality is paramount to the ACG. A great percentage of our patients are 65 years old or older. Many of the patients we treat in the hospital for gastrointestinal diseases are Medicare beneficiaries.

The Medicare hospital prospective payment system is still in the implementation stages across the country. Many of our nation's hospitals are just shifting over to the system. Congress, when preparing the legislative guidelines for the implementation of the prospective payment system, provided for the Secretary of Health and Human Services to adjust the DRG classifications and weighing factors in fiscal year 1986, and periodically thereafter. Presumably, this period between the beginning of the prospective payment system and fiscal year 1986 would allow sufficient time for the hospitals and other health care providers around the country, and patients, to get their feet wet to the system, allow hospitals to adjust their financial and record keeping practices, and operate for a short period of time with the system intact. It was expected also

that the Health Care Financing Administration would need some time to adjust to the system. Further, to assist the Secretary in determining the need for adjustments and fine tuning in the prospective payment system, the Prospective Payment Assessment Commission was created. It was envisioned that the Prospective Payment Assessment Commission would study current and relative trends and data over a sufficient period of time to make thoughtful and informed recommendations to the Secretary.

The American College of Gastroenterology must express concern with the pace at which the Department of Health and Human Services is making adjustments to the prospective payment system. We feel the Secretary, while understandably under pressure to reduce Medicare costs, would be well advised to allow the system to operate for a longer period of time before proposing sweeping, across the board changes to the program. ACG is also in favor of allowing the Prospective Payment Assessment Commission to take a good long look at how the system is working now, and how it can be improved and adjusted in the future, for the future. The elderly of the nation deserve this consideration. It is their health care at stake. A benefit they are entitled to.

Thank you for the opportunity to present the views of the American College of Gastroenterology.

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
ON
MEDICARE PROSPECTIVE PRICING IMPLEMENTATION ISSUES

August 9, 1984

SUMMARY

On July 3, 1984, the Department of Health and Human Services' (HHS) proposed revisions to the Medicare prospective pricing system which address several of the more pressing problems that have been identified as hospitals make the transition from cost-based reimbursement to prospective pricing. However, the Department's proposed Medicare prices for Fiscal Year 1985--also contained in the July 3rd notice--raise two major procedural and substantive issues:

- the extent to which prices are being set through a closed process that provides little opportunity for meaningful participation by either the public or providers; and

- the appropriateness of the various adjustments that have been made in setting the 1985 prices.

Public confidence in the reasonableness of the prices can be maintained only if the data used to establish these prices are publicly available, and if the adjustments to the prices are consistent with statutory provisions. The information used to set prices is critical if providers are both to understand the price-setting process and to view the resulting prices as credible. With respect to the prices, adjustments should not be made for changes in the case mix of the Medicare population that result from the aging of that group or from its more efficient use of acute inpatient settings.

INTRODUCTION

The American Hospital Association (AHA), on behalf of its more than 6,100 institutional and 38,000 personal members, submits the following comments on the proposed changes to the Medicare hospital inpatient prospective pricing system and the proposed Medicare prices for FY 1985.

The AHA supported the adoption of prospective pricing as the best means available of addressing the problems associated with the cost-based payment system under the Medicare program. The purpose of prospective pricing is to establish incentives for hospitals to increase their efficiency in the provision of hospital services. These incentives can be effective only if the prices established by HHS and its Health Care Financing Administration (HCFA) are fair and adequate. Specifically, the prices must be set at a level that enables efficiently operated hospitals to meet the financial requirements generated by Medicare patients.

The July 3rd Notice of Proposed Rulemaking (NPRM) announcing proposed prices for FY 1985 seriously jeopardizes the ability of the prospective pricing system to achieve these objectives.

- First, the notice fails to reveal the data, assumptions, and calculations used in making adjustments to the prices.

- Second, the notice contains a reduction to diagnosis-related-group (DRG) cost weights that is not supported by statute.

The effect of the adjustments made by HCFA is to reduce payments to hospitals, because of changes in the medical needs of the Medicare population, even though every indication suggests that hospital payments are currently running well below projected levels.

CURRENT INDUSTRY PERFORMANCE

The recent performance of the hospital industry offers substantial evidence that incentives are bringing about a major change in hospital costs. The rate of increase in total hospital expenses slowed from 15.8 percent in 1982 to 10.2 percent in 1983. The rate of increase in inpatient expenses fell even more sharply: from 15.6 percent in 1982 to 9.6 percent in 1983. Early data for 1984 indicate a continuation in these trends: the annualized rate of increase in total expenses for the first four months of the year was 5.2 percent. This substantial reduction is not simply the result of changes in demand or marketbasket pressures. As trends in hospital employment and length of stay indicate, a substantial part of the industry's performance in 1983 is due to improvements in hospital efficiency in both the production and use of hospital services.

The trend toward slower growth of hospital employment that has been established over the past several years has continued. The increase in hospital employment was dramatically lower in 1983 than in 1982, and even

lower in 1984. Total employment rose 3.7 percent in 1982 and 1.4 percent in 1983. During the first four months of 1984, employment declined at an annualized rate of 0.7 percent. The patterns for the first part of 1984 are striking. While the reduction in employment resulted, in part, from higher productivity, it also reflected a reduction in the volume of services provided by hospitals.

Total hospital admissions have declined thus far this year. Among the Medicare population, admissions of patients 65 years of age or older increased 4.7 percent during 1983, slightly below the historical trend. Length of stay for patients 65 years of age or older was down sharply--4.5 percent--resulting in almost no net increase in total patient days for patients in this category. The picture is drawn more clearly in the fourth quarter of 1983, with admissions of patients 65 years of age or older increasing by less than 1 percent, while the average length of stay for such patients fell 5.5 percent. Through April of 1984, admissions of patients over the age of 65 actually declined by 1.2 percent, compared to the same period of 1983, while the length of stay for patients over the age of 65 declined by 7.5 percent.

The significance of these trends is readily apparent. Hospitals are responding positively to the incentives created by both prospective pricing and the system of per-case payment established by the Tax Equity and Fiscal Responsibility Act (TEFRA).

PUBLIC DISCLOSURE OF INFORMATION

Under the system of cost-based reimbursement, providers knew the rules that determined payment and had an opportunity to contest the interpretation and application of them. Under prospective pricing, the situation is quite different for the following reasons:

- the "rules" used to set prices are made public only in the most general of terms; and

- providers are forbidden by statute from contesting nearly all of the significant factors determining rates of payment.

Under these circumstances, HHS has nearly unchecked power to set prices. Consequently, it is important for the Congress, the public, and hospital managers to have full access to how the Department sets Medicare prices, an opportunity that can be meaningful only if the data and the studies upon which the prices are based are publicly available. While HCFA officials have met with industry representatives, they have not made available either to hospitals or the public detailed documentation of the data and studies used to establish the FY 1984 and FY 1985 prices, including the information on:

- adjustment of FY 1984 prices for the effects of inaccurate coding of patient diagnosis and surgical procedures on 1981 Medicare bills;

- estimate of FICA re-entry costs;
- adjustment of FY 1984 and FY 1985 prices for "outlier" payments and setting of "outlier" thresholds;
- justification of HCFA's projection of costs under TEFRA rules; and
- estimate of the impact of the change in transfer and other policies on the FY 1985 prices.

In addition, HHS never has made available the data used to set prices or relative DRG cost weights. While the Department has described in general terms the process used to calculate weights and prices, the computations through which prices are set are so complex, and are affected by so many factors, that it is impossible to assess the methodology without having access to the data actually used to set the prices.

HCFA's continuing failure to make public the details of the price-setting calculations violates the intent and provisions of the Administrative Procedures Act (APA). The exemption of federal benefit and insurance programs such as Medicare from the APA was intended to reflect the administrative difficulties associated with compliance with public notice and comment periods for programs affecting large numbers of individuals. However, Congress did not intend to encourage closed rulemaking processes, and recognizing the importance of an open process, HHS voluntarily agreed to comply with the APA

in the past. For this voluntary commitment to be meaningful, HCFA must give interested persons an opportunity to participate in the rulemaking process through comments on both the rules and the factual basis for the rules. In regard to the present NPRM, full disclosure of data and documentation is essential in order for the hospital field to verify HCFA's methodology and assumptions, and to assess the full policy implications of HCFA's proposed actions.

APPROPRIATENESS OF BUDGET NEUTRALITY ADJUSTMENT

The central substantive issue posed by the notice of proposed FY 1985 prices is the meaning of "budget neutrality." HHS has adopted a definition of budget neutrality that appears to be inconsistent with both the letter and spirit of the prospective pricing legislation. The Social Security Amendments of 1983 granted the HHS Secretary broad authority to set prices, requiring that:

- for FY 1984 and FY 1985, the prices be set at a level that would result in total payments neither greater nor less than they would have been under a continuation of the cost-per-case limits established by TEFRA; and

- for FY 1986 and beyond, the prices be set at a level that would reflect changes in marketbasket prices, changes in technology, and changes in hospital productivity.

The proposed adjustments to the FY 1985 prices are intended to comply with the first of these requirements. The AHA believes that Congress intended the concept of "budget neutrality" to be a general guideline to be used by the HHS Secretary in excercising his or her broad discretionary authority to set prices.

Several factors must be considered when making adjustments to the prices to ensure "budget neutrality." Among the factors that legitimately may be taken into account are:

- the effects of reducing the cost-per-case limit on allowable costs established by section 1886(a) of the Social Security Act from 115 percent to 110 percent of the mean for each hospital peer group;

- the effect (if any) of eliminating the "forgiveness" of 25 percent of the difference between the actual cost-per-case and the target limits established by section 1886(b) of the Social Security Act for hospital fiscal years beginning on or after October 1, 1984;

- the effect of the changes in HCFA's policy on definition of Part A and Part B Medicare services, FICA re-entry, tranfers, outliers, and other items; and

- the effect of errors in diagnostic and surgical procedure coding on the accuracy of the 1981 MEDPAR case-mix index used to adjust both

the hospital component of the DRG price and the federal "standardized" prices.

The proposed schedule of prices includes adjustments for these factors, although the validity of the adjustments cannot be evaluated using the scant information and data that are currently available. The AHA urges the Department to make available all of the supporting data used to set prices, particularly the data supporting the calculation of TEFRA savings.

In addition, HCFA has reduced the prices, through an adjustment to the DRG relative cost weights, to eliminate the effect of changes in the overall case mix of the Medicare population between 1981 and 1984. This adjustment is supported neither by the statutory provisions, the Department's own regulations, or good public policy.

The statute explicitly directs the Secretary to assess periodically the DRG cost weights, making adjustments when needed to reflect the effect of changes in technology on the relative costliness of DRGs. While the statute does require the Secretary to adjust prices in 1984 and 1985 to ensure that expenditures under prospective pricing would be neither greater nor less than expenditures under the TEFRA cost-per-case limits, nothing in sections 1886(a) or 1886(b) of the Social Security Act enables the Secretary to ignore the effect of changes in case-mix on costs. Section 1886(b)(4)(A) states:

"The Secretary shall provide an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount

of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost-reporting period." (Emphasis added)

Thus, the TEFRA limits should be adjusted for changes in case mix, and changes in case mix of the Medicare population would have resulted in changes in both total and per-case payments. Consequently, as changes in the overall case-mix of the Medicare population would have resulted in changes in payment under the rules established by TEFRA, no adjustment should be made to the FY 1984 and FY 1985 prices for changes in the case mix of the Medicare population.

The Department's own regulations implementing sections 1886(a) and 1886(b) explicitly establish changes in case mix as an allowable ground for an exception to both the limit on allowable costs (42 CFR 405.460[g][9]) and the limit on the allowable increase in cost-per-case (42 CFR 405.463[e]). The Department also has issued instructions to Medicare fiscal intermediaries on the processing of requests for exceptions to the limits based on changes in case mix. Therefore, it is not possible to argue that changes in case mix would not have affected payments under the system of TEFRA limits.

Finally, sensible public policy provides the reason why changes in the case mix of the Medicare population should not affect the level of prices. As the case mix of the Medicare population changes, the cost of treating the average Medicare patient will change. Generally, changes in case mix increase costs.

If the cost weights, or the prices, are reduced to counter the increase in costs due to changes in case mix, Medicare payment will be insufficient to cover the cost of providing services to the Medicare population. The proposed adjustment transfers the risk of an increasingly costly case mix for the Medicare population from the Medicare program to other payers and to the non-Medicare population--resulting in a subsidy of the Medicare program by the community. The decision to reduce the DRG cost weights also runs counter to HCFA's efforts to encourage the substitution of outpatient services for inpatient services through the Peer Review Organization program. To the extent that these efforts succeed, the cost of treating the remaining patients will increase as only the more complex cases will be treated on an inpatient basis.

Based on these considerations, the AHA believes that no adjustment is justified for changes in case mix between 1981 and 1984. The only legitimate adjustment for coding is for that done inaccurately on 1981 MEDPAR bills. While the study used by HCFA to make the 3.38 percent adjustment to FY 1984 prices has been kept confidential, the method apparently used in the study is the only legitimate way of correcting for the effect of improved accuracy of diagnostic and surgical procedural coding. Only a comparison of 1981 case-mix indices calculated using accurate and inaccurate data for 1981 reflects the effect on outlays of errors in coding. As any comparison of 1984 to 1981 case mix will result in an adjustment for real changes in case mix, the adjustment proposed by HCFA is clearly inconsistent with the provision of the Social Security Act.

The AHA remains firmly committed to establishing an effective prospective pricing system. The performance of the hospital industry in the last six months demonstrates the positive results that the hospital field has been able to produce. To ensure the continuation of these trends, it is essential that prices be established that are both fair and adequate, and that the data used to establish these prices be made available for public examination.

STATEMENT OF THE

FEDERATION OF AMERICAN HOSPITALS

SUBMITTED FOR THE HEARING RECORD ON

THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT RATES

PROPOSED FOR FISCAL YEAR 1985

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

AUGUST 8, 1984

The Federation of American Hospitals is the national association of investor-owned hospitals representing over 1,100 hospitals with over 135,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on the adjustments being made by the Secretary of Health and Human Services to the diagnosis related groups (DRG) relative weights for Fiscal Year 1985 under the Medicare prospective payment system.

Our association endorsed the concept of prospective payment for Medicare hospital services more than 15 years ago and we supported the historic change in the Medicare payment system enacted last year. We have always believed that strong economic incentives for increased management efficiency would contain Medicare costs but even the strongest supporters of such change were pleasantly surprised by how quickly these incentives began to work. Hospital costs have been contained over the past year for Medicare and for all other payers as hospitals changed their behavior to hold the line on the growth of employees, reduce length of stay, and with the cooperation of medical staffs, revise utilization and seek alternatives to hospital care.

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Exhibit One tells the story of this dramatic trend which has benefited all who bear the cost of hospital services. The growth in total costs and costs per case is declining dramatically relative to the consumer price index and the hospital market-basket. What makes this performance especially remarkable is that prices themselves have been rising much less rapidly. From the quarter ending February 1982 through the quarter ending February 1984, the rate of increase in total hospital expenses dropped 65 percent, from 17.2 percent to only 5.9 percent (Exhibit One). The rate of increase in expenses per admission dropped by over half from 19 percent to 8.2 percent (Exhibit One). The decline in the growth rate of total hospital expenses and expenses per admission has been much greater than the decline in the consumer price index which over the same period dropped by 40 percent from 7.7 percent to 4.6 percent.

The hospital industry now awaits final regulations for fiscal 1985 Medicare prospective payment, and we are greatly concerned about the fairness of payment increases which according to the law should reflect changes in the hospital market basket of goods and services hospitals must purchase. That market basket increase of 6.4 percent plus 1/4 of 1 percent has been reduced for budget neutrality to 5.6 percent in the proposed regulations. However, we are most concerned about that provision of the proposed regulations which would reduce all DRG weights

by 2.4 percent. This change in weights was not only unanticipated by the nation's hospitals, but could undermine support for this new system's alleged predictability and fairness.

Most institutions have budgeted for actual cost increases of about six percent in fiscal 1985. The government's budget for Medicare expenditures in fiscal 1984 is showing a $2 billion savings from lower than anticipated admissions and other increased efficiencies from the new prospective payment system. If hospitals are penalized when they are performing so much better than anyone predicted, there is bound to be an adverse reaction which could jeopardize this new program.

Predictability of prospective payments is essential for the budgeting process of both government and industry. Fairness of payment levels is also imperative if the industry is to be able to contain Medicare costs without shifting costs to other payers. Those who criticized a Medicare only prospective payment system warned that hospitals would simply raise prices to private payers. Those critics were wrong because they underestimated the impact of Medicare policy on total costs. Hospitals have cut costs because for the first time since Medicare was enacted, Congress offered an economic reward for cost reducing behavior. If the proposed reduction of DRG weights is not deleted in final regulations, the Medicare program will have increased the chance

that some hospitals will resort to price increases as the only way to achieve adequate revenues other than reducing necessary services.

For these reasons, we express our appreciation to the Chairman for scheduling this important hearing and we urge the Committee to help clarify the intent of Congress with regard to the long range importance of assuring fair and predictable payments for hospital services to Medicare beneficiaries.

In the recently issued conference report on the Budget Deficit Reduction Act of 1984, the Congress expressed their concern that proposed fiscal 1985 Medicare prospective payment rates for hospital services be both budget neutral and fair. In part the report urges the Secretary of HHS "to carefully evaluate the potential impact of rates on the long-term success of the prospective payment system."

Attached to this testimony is a copy of our association's comments to the Department of Health and Human Services on the proposed weight reduction. The following points are included in those comments:

1. The Health Care Financing Administration (HCFA) did not test the data to determine whether fiscal 1984 Medicare inpatients were on average older and more severely ill than fiscal 1981 patients. We believe

that the trend reflecting treatment of less severely ill patients in outpatient settings indicates a higher average case mix for inpatients rather than simply improved accuracy in coding.

2. The data base of 896,000 fiscal 1984 discharges used by HCFA does not appear to be representative of Medicare cases on a geographic or case-mix basis.

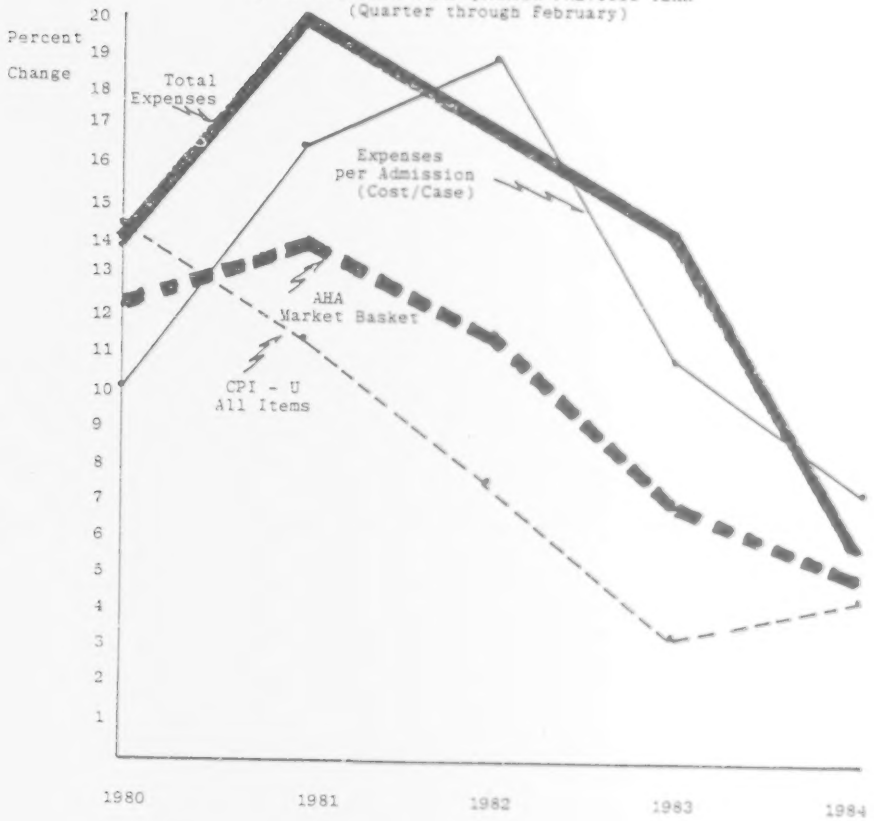
3. The hospital industry has been denied access to the HCFA data bases, methodologies, assumptions, and formulae which produced the DRG weights.

4. The statutory language, in our opinion, precludes application of a budget neutrality adjustment to the DRG weights and also precludes changes in the weights prior to October 1, 1986.

For reasons of fairness and the absence of adequate data, we believe DRG weights should not be changed in fiscal 1985 but should be reviewed with the help of the Prospective Payment Assessment Commission in fiscal 1986 as directed by the statutory language.

EXHIBIT ONE

% CHANGE FROM SAME QUARTER PREVIOUS YEAR
(Quarter through February)



Federation of American Hospitals
Michael D. Bramberg, Esquire, Executive Director

National Offices 1111 19th Street, N.W., Suite 402
Washington, D.C. 20036 Telephone 202/833-3090

July 25, 1984

Carolyne K. Davis, Ph.D., Administrator
Health Care Financing Administration
Post Office Box 26676
Baltimore, MD 21207

Re: BERC-279-Proposed Changes to PPS Regulations and Rates for FY 85, Federal Register, July 3, 1984

Dear Dr. Davis:

The Federation of American Hospitals, representing the investor-owned hospital and health care systems industry, urges you to delete in the final rule the proposed reduction in DRG weights as published in the July 3, 1984 Federal Register. The proposed rule discusses this issue on pages 27442 through 27445 and includes the new proposed weights as Table Five of the document.

We have four basic concerns which we shall discuss in detail:

1. HCFA Assumptions on Patient Mix;

2. Inadequate and Unrepresentative PPS Sample;

3. Inability to Access HCFA Data Base; and

4. Statutory and Congressional Intent.

PRESIDENT

ADMINISTRATIVE & MEMBERSHIP SERVICES OFFICE

The Federation strenuously objects to and vigorously opposes an additional reduction of 2.4 percent -- to be factored uniformly in FY 85 on DRG weights -- for the following reasons:

1. HCFA Assumptions on Patient Mix

The explanation of the 5.85 percent reduction factor of which 3.38 percent was incorporated into FY 84 rates indicates that it was based on 896,000 discharges under the prospective payment system through March 1984. Further, that these discharges were matched hospital by hospital and month by month "to compensate for any biases that could have been due to seasonal variations, hospital cost-reporting period distributions and the timeliness of submitting bills." The major flaw in this assumption is that each hospital, each month, in 1981 -- the MEDPAR year -- and in 1984, -- the PPS year -- treated patients with the same characteristics. This assumption was not tested and probably could not be tested unless an expensive, time-consuming, and exhaustive analysis was conducted using medical record source documents, as distinguished from billing and claim form data that was the only documentation used for both the 1981 and 1984 determinations. Our hypothesis is that 1984 patients are on average older and therefore relatively more severely ill. Also, there has been a trend that has been accelerating over the time period in question which reflects movement of less severely ill patients to outpatient treatment settings, leaving the more acutely ill to be treated as inpatients. This aspect alone would be indicative of a higher case mix for all hospitals that would not be accounted for by more accurate coding. Further, the rate of increase in Medicare inpatient admissions has been decelerating for the last three years with a concurrent acceleration of outpatient visits. This also is evidence of this trend.

2. Inadequate and Unrepresentative PPS Sample

As previously mentioned, 896,000 discharges billed under PPS through March 1984 were used as your 1984 data base. According to HCFA Fact Sheet, May 1984, as of March 31, 1984, only 43 percent of all hospitals were operating under PPS. Further, an estimated 4.8 million patients were admitted from October 1, 1983 through February 29, 1984. Therefore, less than a 20-percent sample of discharges were used from only 43 percent of all hospitals. In addition, many of the 57 percent of hospitals not on PPS as of March 31, 1984 are hospitals that treat the most complex cases. It [illegible] assumption can be made from patient

comments by HCFA staff explaining budget neutrality and the HHS News Release of June 18, 1984, discussing the phasing-in of hospital accounting years. To be a representative sample, a data base of discharges from the entire year of 1984 should be used to compare with the 1981 MEDPAR file, which used bills from patients discharged for that entire year. The 9 million bills used from the PSRO data set was a far more valid and representative sample. HCFA staff did not know at the recent PPS briefings the geographical breakdown of the 896,000 discharges which were used as the basis to determine that improved diagnostic coding for the entire hospital industry was creating a 5.85 percent overpayment.

3. Inability to Access HCFA Data Base

Both the Federation of American Hospitals and the American Hospital Association for more than a year have requested formally, and under the Freedom of Information Act as well, copies of and access to the complete data bases, methodologies, assumptions, and formulae that produced the initial DRG weights. In particular, requests for the complete 1981 and 1982 MEDPAR files have been denied on the basis that they contain "information of a confidential nature, the release of which might constitute an unwarranted invasion of personal privacy." You also claim that even if the "patient identifier" were removed, as we asked, to overcome the privacy issue, other information on the tape -- but not further explained to us -- still could compromise privacy. We feel it is patently unfair for the hospital industry to be denied access to aggregate data that in no way would identify any individual nor invade any personal privacy.

The hospital industry has been a willing partner in the establishment of a Medicare prospective payment system. To deny us access so that our own analysts can examine your methodologies, assumptions, and formulae and then compare your findings with ours is an unwarranted obstacle to a fair exchange of data. Even when data are made available, sufficient time must be provided for an in-depth analysis. Time is always on the regulatory side. The proposed rule in question published on July 3, 1984, with a 30-day comment period to August 2, and final rule due on September 1 to be effective October 1, 1984, leaves little or no time available for the hospital industry to obtain data, analyze it, and react.

4. Statutory and Congressional Intent

The Federation questions whether the Secretary of Health and Human Services has the statutory authority to adjust DRG weights in order to maintain budget neutrality and whether the Secretary has statutory authority to recalibrate weights prior to fiscal year 1986. In both instances, the Federation's general counsel, Weissburg & Aronson, concludes that the Secretary does not have such statutory authority.

The statutory procedure for establishing the federal portion of the DRG rate also supports the conclusion that budget neutrality may not be achieved by adjusting the DRG weighting factors. Section 1886(d)(3) sets forth, in order, the various steps involved in establishing the DRG rates for fiscal year 1985. The third step, after updating the standardized amounts and reducing for outliers, is to adjust total payments for budget neutrality. Section 1886(d)(3)(C). The final rate is then determined in a fourth step by combining the adjusted standardized amount and the weighting factors. Section 1886(d)(3)(D). This procedure is mirrored by the regulations. 42 C.F.R. Sections 405.473(c)(4) and (5). The implication from this ordering is that the aggregate amount of payments must be budget neutral before the weighting factor is introduced. Therefore, budget neutrality cannot be created by an adjustment to the DRG weights.

The Medicare Act does not appear to allow the Secretary to adjust DRG weights prior to 1986. Congress, in fact, deleted language from the House and Senate bills which would have allowed such adjustments.

With respect to Congressional intent, conferees on the recently enacted Deficit Reduction Act (P.L. 98-369), in discussing new payment rates urged the Secretary to "carefully evaluate the potential impact of the proposed rates on the long-term success" of the prospective payment system. The conference report further states "The conferees realize that the appropriateness of the new levels of payment will be vital to the success of the full implementation of the prospective payment system." For the Department to undermine a proposed rate increase, which although inadequate can be lived with, by arbitrarily reducing the DRG weights, appears to be not only a violation

of the spirit but of Congressional intent in setting new levels of payment.

In summary, we urge you in the final rule to restore the DRG weights to those applicable for FY 84. We believe that patient case mix has become higher over the last three years because hospitals are treating more severely ill cases as those less acutely ill have been moving to outpatient treatment facilities. We also find the data base of 896,000 cases of PPS discharges on which you base your determinations to be statistically invalid and unrepresentative of the entire hospital industry's Medicare patient population. We further urge you to release to the hospital industry MEDPAR and other data requests so that proper analysis can be made by us. Also, we believe the Secretary does not have the statutory authority at this time to change the DRG weights to achieve budget neutrality. Finally, we believe the proposed DRG weight reductions are not in keeping with the spirit or intent of Congressional conferees on the Budget Reduction Act.

Please note that this is not the complete Federation response to the proposed rule. However, we feel the topic of DRG weight reduction is of such importance that it merits special attention. Our formal response, which covers this topic as well as comments on other aspects of the proposed rule, will be forwarded separately.

If we can be of further help in clarifying any of our points or in assisting you in any way, please let us know.

Sincerely,

Michael D. Bromberg

Michael D. Bromberg
Executive Director

MDB:clw
cc: Honorable Margaret M. Heckler
Secretary, Health and Human Services

Healthcare Financial Management Association

Ronald R. Kovener, FHFMA, CAE, Vice President

STATEMENT OF THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH
SENATE COMMITTEE ON FINANCE
ON
PROPOSED ADJUSTMENTS IN MEDICARE'S
PROSPECTIVE PRICE SETTING (PPS) SYSTEM

August 13, 1984
(hearing held August 8, 1984)

Summary

The Healthcare Financial Management Association strongly opposes the Health Care Financing Administration's proposed downward adjustment in diagnosis related group weights and recommends that the proposal be withdrawn immediately. HFMA opposes the adjustment because it:

o inappropriately seeks to penalize hospitals for:

  -- meeting PPS' objectives of lower utilization and reduced Medicare outlays

  -- treating more complex cases that use a relatively greater share of resources

  -- appropriate changes in case mix that result from a variety of causes

o is calculated inappropriately because:

  -- it assumes that individual hospitals have the same pattern of cases each year

  -- the sample used does not adjust for hospitals that were only under PPS for a short portion of the study period

  -- the sample is not representative since it excludes hospitals with later starting fiscal years

o is magnified by the budget neutrality calculation

o is inequitable, violates basic principles of the PPS system, and undermines the spirit of cooperation needed to make the PPS system a success.

1050 17th Street, NW ● Suite 510 ● Washington, D.C. 20036 ● Telephone: 202/296-2920

The Healthcare Financial Management Association (HFMA) represents more than 24,000 individual members who are financial managers of healthcare providers or who are closely associated with the financial management activities of healthcare providers. These members are involved in and concerned with the implementation of the prospective price setting (PPS) regulations and the fiscal stability of their organizations.

HFMA strongly opposes the Health Care Financing Administration's (HCFA) proposed downward adjustment in diagnosis related group (DRG) weights, and recommends that this portion of the proposed PPS rules be withdrawn immediately.

HFMA objects to the nature of the proposed DRG rebasing and to the methdology used by HCFA to compute the adjustment. In our view, the proposed adjustment is inappropriate, patently inequitable, violates basic principles of the PPS system, and undermines the spirit of cooperation needed to assure that the program's significant first-year achievements will continue in fiscal year 1985 and future years.

The Nature of the Adjustment

HCFA's proposed adjustment of DRG weights inappropriately seeks to deny payment for changes in services for which hospitals should be paid. The approach described in the July 3, 1984, Federal Register attempts to measure the change in the case-mix index between the 1981 MEDPAR file data and the experience of

PPS hospitals thus far. Implicitly, the method adjusts for changes in case-mix for any and all reasons. These reasons could include:

-- improved accuracy of coding

-- service to patients who required and received a higher order DRG (because of technological advances, an aging population or other reasons)

-- an increase in the average case-mix index due to a shift of some cases to outpatient services

-- "gaming," or the inappropriate assignment by a hospital of a higher-payment DRG than justified by the medical diagnosis.

Since the method utilizes measures and adjusts for the aggregate changes in case mix, all of the above types of changes (and probably others) are included in the adjustment. While Medicare should adjust for "gaming," this can and should be done on a hospital-specific basis. HCFA has acknowledged that there is no evidence of generalized "gaming," so any adjustment for this reason should relate only to specific institutions.

A basic principle of PPS and DRGs is to recognize differences among institutions. The system also recognizes that services change over time. HCFA's proposed adjustment in DRG weights seeks to avoid any recognition that services change over time --

even denying changes hospitals implemented in response to the new PPS incentives. For example, if a hospital has been able to provide quality care in a more cost-effective manner by treating some patients as outpatients rather than inpatients, the average cost for remaining inpatient cases will doubtless be higher. HCFA's method denies payment for this type of change.

The Methodology of the Adjustment

HCFA's method of calculating the proposed DRG weight adjustment is invalid for three reasons. First, an assumption that the same services are provided every year is an incorrect basis for the adjustment. The method used assumes that discharges, by month, are uniform within each hospital each year. For example, the calcuation assumes that Hospital A always serves the same proportion of myocardial infarction patients every March. There is no definitive data that supports such an assumption for this type of analysis.

Second, the reasonableness of the sample used also raises questions. Since only those hospitals under PPS through March 1984 were used, each hospital is weighted only for the months it has been on PPS. It appears there was no adjustment for phase-in characteristics unique to hospitals that were only in the system for one or two months of the study period.

Finally, there is the question of whether the hospitals sampled are representative. Many hospitals have July 1 fiscal years and

are, accordingly, excluded from the sample. HFMA understands from other HCFA data that hospitals with later starting fiscal years tend to be larger than average and represent a substantial number of discharges. The new PPS regulations will be used to adjust payment for all hospitals, even those not represented by the sample. Because of their size, hospitals excluded from the sample could have a significant influence on the results.

However, even if problems with the sample were corrected, the initial shortcoming previously described (i.e., the assumption that each hospital has the same pattern of cases each year) would be sufficient to render the method invalid.

The Budget Neutrality Calculation

The inequity of the rebasing of DRGs is magnified by the "budget neutrality" calculation. As HFMA understands "budget neutrality," it was Congress' intent that HCFA pay in accordance with the PPS formula, but with the restriction that overall spending may not increase beyond what would have occurred under Tax Equity and Fiscal Responsibility Act limits.

Concerning budget neutrality and its place in the development of new PPS rates, conferees on the recently enacted Deficit Reduction Act (P.L. 98-369) wrote:

> Recognizing that budget neutrality will be a primary consideration in the establishment of the fiscal year 1985 hospital payment rates, the conferees are nevertheless concerned about the perception that they

> may be unfair and inequitable. The conferees realize that the appropriateness of the new levels of payment will be vital to the success of the full implementation of the prospective payment system. ...the conferees urge the Secretary to carefully evaluate the potential impact of the proposed rates on the long-term success of the prospective payment system.

In developing the proposed fiscal year 1985 rates, however, HCFA has used the budget neutrality provision as a spending "cap" that penalizes hospitals for achieving the very objectives of the PPS system -- lower admission rates and reduced Medicare spending. A brief example will illustrate this point.

> Assume that a hospital serves nine cases at $105 each, plus one simple case costing $55, for an aggregate cost of $1,000. With a 10 percent inflation provision, it is assumed the budget neutrality "cap" would be $1,100. If the hospital reduced admissions by treating the simple case on an outpatient basis and treated only the harder, more expensive cases as inpatients, the second year payment would be nine cases at $105 each, or $945. Factoring in 10 percent inflation raises the total to $1,040 -- an amount lower than the $1,100 budget neutrality cap. However, the budget neutrality cap has been calculated to penalize hospitals for reducing the number of admissions. The cap is calculated by taking the original $100 average per case times nine cases plus 10 percent inflation, or only $990. Thus, every case price would be cut by 4.8 percent even though if the higher payment were made, the government would save 5.4 percent from what it would have spent.

The Adjustment is Inequitable and Undermines Hospitals' Spirit of Cooperation Toward PPS

In a recent presentation to the National Association of Counties, Health and Human Services Secretary Margaret Heckler pointed with pride to the reduced rate of inflation in healthcare prices. HFMA and the healthcare industry share the Secretary's pride in this achievement, which was accomplished through cooperative effort. However, such cooperation will be undermined by a payment adjustment that penalizes hospitals for the achievements they have made. PPS established a new financial relationship between the Federal government and hospitals that is based on the understanding that cost-effective performance will be rewarded. Hospitals have accepted an administered price arrangement in anticipation that they will be treated equitably. However, HCFA's proposal undermines the basic incentive structure of the PPS system. If hospitals are not allowed to share in the benefits of their cost-saving initiatives, they will no longer seek to achieve savings. Other payors will be denied the relief from inequitable Medicare payments which they expected and cost shifting will continue. Hospitals will be forced to tailor programs to the inadequate DRG payments provided, thus denying Medicare patients the benefits of new technology, and the access, comfort and dignity they deserve.

As Secretary Heckler has pointed out, the Federal government already has saved far more than it expected from PPS. The good-faith efforts of hospitals are largely responsible for the success of the PPS program, and hospitals should be allowed to

share in the savings that have been achieved to date. However, HCFA's proposed downward adjustment in DRG weights would penalize, rather than reward, hospitals for their cooperation in making PPS a success. The HCFA proposal is inequitable, violates the basic principles of the PPS program, and undermines the spirit of cooperation needed to make the new payment system a success. We recommend that it be withdrawn immediately.

HFMA is pleased to submit its views on this important PPS topic. We will be pleased to answer questions or provide additional information on any issue addressed in our statement.

* * *

STATEMENT OF THE KANSAS HOSPITAL ASSOCIATION

FOR THE

SUBCOMMITTEE ON HEALTH OF THE SENATE FINANCE COMMITTEE
OF THE UNITED STATES SENATE

ON THE ISSUE OF THE IMPLEMENTATION
OF THE PEER REVIEW ORGANIZATION PROGRAM

Hearing Date: July 31, 1984

Dear Senator Durenberger and Members of the Subcommittee:

The Kansas Hospital Association (KHA), on behalf of its 180 member hospitals and health care related institutions, appreciates this opportunity to comment on the implementation of the Peer Review Organization (PRO) program.

KHA supports the development of an effective utilization review program which focuses on the quality and the medical appropriateness of the care furnished to Medicare beneficiaries. However, we are concerned about the PRO program as it is currently being implemented by the Health Care Financing Administration (HCFA) in response to the Peer Review Improvement Act of 1982. KHA believes the congressional intent in passing this legislation to authorize replacement of Professional Standard Review Organizations (PSROs) was to streamline and simplify the process for the government as well as the medical community. This means the new PRO program should be cost efficient, beneficial and effective for both the government and hospitals. Our specific concerns include: the establishment of PRO objectives; the denial rate and its implications for hospitals' waiver of liability; the lack of opportunity for public comment and participation in the development of PRO policies and procedures; the centralization of the PRO review process which has resulted in a shifting of costs from the PRO to the hospital; data confidentiality; and the physician's attestation statement. Generally, KHA

is recommending there be complete and open communication and the development of a truly working relationship rather than an adversarial relationship among HCFA, the PROs and the providers. In addition, KHA believes that HCFA should:

- grant the PROs more flexibility in establishing their review procedures and objectives;
- provide for considerably more confidentiality of data;
- recognize the additional costs being borne by hospitals as a result of the new review process; and
- establish incentives to recognize and reward those hospitals that are doing an effective job of utilization management.

KHA appreciates the continued interest the Subcommittee has shown in the PRO implementation and its assistance in the enactment of certain amendments to the Deficit-Reduction Act of 1984. KHA strongly believes that the PRO governing board should be a forum where medical review policies can be addressed by a cross section of community interests which include providers. By permitting hospital representation, Congress has recognized the PRO program should not be an adversarial one, but rather one where federal government, physicians and the hospital industry can become working and willing partners in building a new review program -- a program which is administratively rational and cost effective, while at the same time tailored to address the incentives created by Medicare's new Prospective Payment System (PPS). The ability of these parties to work together during this

critical period of transition will set the tone for the future and may well determine the success or failure of not only the PRO program, but the Medicare program in general.

Specific PRO Implementation Issues:

I. PRO Objectives

We will not go into the details of the specific PRO review activities. These have already been outlined in the background paper prepared for the use of the members of the Subcommittee and in the comments of the American Hospital Association and the American Medical Peer Review Association. However, we do want to note our deep concern with the prescriptive approach to the review that is being taken by HCFA. This type of review burdens good hospital and physician performers with unnecessary monitoring and additional costs. And does not provide the PRO physician advisors and staff with the flexibility to concentrate on activities in identified problem areas or with specific providers.

Many of the PRO review plan categories mandated by HCFA overlap with the objectives HCFA is negotiating in the PRO contracts. Furthermore, it does not appear reasonable to expect a single uniform approach to effectively address the different quality of care and utilization problems throughout the nation. This variance in medical care is demonstrated by a study recently released by Project HOPE. The study specifically identified wide variations in use rates for various medical procedures. Not surprisingly, the study goes on to state that the wide variations are primarily the result of "practice style". "Practice style" or how and in what setting a

physician is likely to treat a particular medical problem can be the result of many factors including the doctor's age, the practices in vogue when he or she attended medical school, the particular medical school he or she attended, the community in which the physician lives, the attitudes towards defensive medicine and the practice patterns of other doctors in that community. The study found these factors result in individual practice styles which combine to create recognizable "medical signatures" for different communities. Since physicians direct about 70 percent of this country's health care expenditures, practice styles and medical signatures are important variables in any utilization or cost equation. However, researchers indicate it is impossible to know whether a particular procedure's low use rate in one community or high use in another is more appropriate. To make such determinations, controlled studies producing hard data are needed.

To effectively address the necessary changes in practice style, several steps need to be taken. First of all, the procedure use rates, hospital admission rates and outcomes of different areas must be monitored. This information should then be gathered, analyzed and eventually disseminated to hospitals and physicians to create a greater awareness of cost-effective practice styles. Physician education is the key in this effort.

Physicians and hospitals do not want to overuse, misuse or unnecessarily drive up health care costs. Many of the practice styles of today are due largely to uncertainty and the practice of conservative or defensive medicine. The medical literature today contains little hard data on the outcomes and consequences of most procedures. Once these are known, physicians and hospitals will alter their behavior appropriately in

response to the new information. This type of education and research, which in the long run could most effectively benefit the Medicare program and the health care of the United States, appears to be lost in the new Peer Review Organization program. The rigidity of the procedures, the setting of absolute numerical objectives often without regard to medical necessity, and the lack of PRO funding to (1) provide on-sight review and education to hospitals and physicians; and (2) to refine and work on definitions and measurements of quality and cost-effective medical practice insures that these types of questions and positive activities will not be undertaken by PROs.

While the PRO legislation specifically called for negotiated objectives against which the PRO's performance would be judged and measured, HCFA's use of goals related to "the elimination of avoidable deaths" and "reductions in admissions" are beginning to cause serious concerns not only in hospitals and with physicians, but also with the public. While HCFA argues that the numerical "goals" are based on information obtained in each state, and therefore representative of the needs of those communities, generally these objectives have been established using national norms and comparisons which may not be appropriate. Furthermore, HCFA seems to be set on requiring a set number of admissions to be reduced rather than relating these objectives to a reduction in the rate of Medicare admissions per thousand. In addition to this, HCFA is not allowing the PRO to tailor their objectives to meet specific local needs once the PRO has had a chance to thoroughly evaluate and analyze the actual situations with respect to each of their objectives. Right now these objectives are based on data which indicates there "appears" to be a problem rather than situations where it is actually known by the PRO that a problem exists. This could

result in situations where the PRO is trying to address and being held accountable for objectives in an area that eventually turns out to be a non-problem area.

The Kansas Hospital Association therefore recommends that HCFA grant the PROs the flexibility to re-negotiate and alter not only their objectives, but also their review plans, to meet the needs of the community(s) they serve; to provide education and research to assist in evaluation and changing of "practice styles," if change is needed; to establish objectives geared towards reducing the Medicare admissions on a rate per thousand basis rather than on a set number of admissions for each objective; and to specify that any reductions in rates are to be solely from the elimination of medically unnecessary or inappropriate care.

II. Denial Rates/Waiver of Liability

Many of the formulas established as part of HCFA's utilization review program fail to distinguish between hospitals and physicians with good review records and hospitals and physicians with utilization problems. Regardless of a hospital's review experience, the hospital can expect to have a minimum of 25 to 35 percent of their Medicare cases reviewed. In addition, the denial rate is set extremely low at 2.5 percent. This rate is used by HCFA for determining whether a hospital will be subject to 100 percent review of its cases and for determining whether a hospital will have a favorable waiver of liability presumption. If a hospital does not have a favorable presumption, it will be subject to retroactive payment denials. We recognize that a 2.5 percent denial rate was used prior to the

PRO program. However, HCFA's methodology for calculating the denial rate has changed significantly. Rather than dividing the number of Medicare admissions denied in the PRO's review by the total number of Medicare admissions to the hospital, HCFA is now dividing the number of Medicare admissions denied in the PRO's review by the Medicare admissions the PRO reviewed for the quarter. In Kansas, this has resulted in only five hospitals falling under the new criteria or the 2.5 percent denial rate. In other words, virtually all Kansas hospitals are now subject to 100 percent review of their medical records. This also means that these hospitals no longer have a favorable waiver of liability presumption. In Kansas, most of these hospitals on a 100 percent review are small, rural hospitals, and are now being required by the PRO to copy and mail their medical records to the PRO for review. This creates additional administrative burdens for not only the hospitals but for the PRO. It also creates considerably more additional costs for these hospitals to comply with the PRO program's requirements. And finally, it is also these small, rural hospitals that are at an extreme financial risk for potential cases that may be denied as a result of the PRO review, since their waiver of liability has been revoked.

The Kansas Hospital Association does not believe a 100 percent review is beneficial or cost effective for either the Medicare program or the hospital. Such review should only be undertaken in hospitals where there has been a demonstrated problem. We suggest HCFA establish positive incentives for hospitals and physicians with good review records by allowing for flexible review procedures and the delegation of review functions where the hospital has demonstrated the effectiveness of its in-house utilization management program. KHA believes it was Congress'

intent to provide PROs with such flexibility and to reward provider behavior rather than constantly penalizing providers. At the very least, PROs should be able to eliminate HCFA-required review activities when the PRO can demonstrate that the review process is not uncovering patterns of inappropriate hospital behavior.

It is time to reward those who are good performers and target utilization review energies where the payoff is the greatest. HCFA appears to be deliberately eliminating any possible waiver of liability for the hospital, and basing this loss of waiver on a process that is a "hindsight," and sometimes subjective, review. HCFA should be requested to establish more realistic and reasonable denial rates and instructed to preserve rather than eliminate a hospital's favorable waiver of liability presumption unless it can be shown that the hospital has been extremely negligent or fraudulent in its utilization management or medical record documentation.

III. Lack of Provider/Public Participation

KHA is upset with HCFA's delay in publishing the regulations governing implementation of the PRO program and the interim implementation of PRO policies and procedures without an opportunity for public comment. Currently the PRO program is being implemented and PRO contracts are being negotiated without any final regulations governing the conduct review, the reconsideration and appeal process, the sanction procedure or the acquisition and disclosure of data by PROs. While Notices of Proposed Rule Makings (NPRMs) have now been issued governing each of these areas, the latter two were not issued until April, almost 20 months after the passage

of the Peer Review Improvement Act and the first two NPRMs were just issued July 17. The provisions of the NPRMs have been implemented in the interim by HCFA via PRO transmittals or letters and other non-public PRO communication channels. Thus, major changes and revisions to the PRO program are often being imposed on hospitals without notice and have still been incorporated in HCFA's Request For Proposals (RFPs), and the PRO-HCFA contracts now being signed.

When regulations were finally issued, the public comment period was limited to 30 days. This provides little time for dissemination of the proposed rules to Kansas hospitals and the preparation of informed and constructive comments. Furthermore, since the PRO contracts and related technical proposals are currently being negotiated between the PROs and HCFA, and since these include the provisions of the regulations or proposed rules, it appears HCFA does not plan to sincerely evaluate and consider any public comments.

In addition to the lack of adequate opportunities to comment, hospitals are being given little opportunity for a meaningful negotiation of their PRO-hospital agreements. PROs have been instructed in their negotiations with HCFA (1) basically where to perform on-sight versus off-sight review; (2) not to reimburse any additional costs incurred by hospitals as a result of having to copy and mail records or undergo a 100 percent review; (3) the procedures (or lack of them) to use in preserving the confidentiality of data; and (4) the specific review procedures the PROs are to use. PROs are also being instructed to obtain agreements with hospitals immediately, while at the same time HCFA is making these agreements subject to the

yet-to-be-released HCFA guidelines. Lastly, if hospitals do not sign the PRO agreement, even though they may have some valid and legitimate concerns with the agreement, they will lose their Medicare participation.

KHA is committed to working with HCFA and our area PRO to establish and maintain effective working relationships between hospitals, physicians and PROs. We feel fortunate in Kansas that our PRO has attempted to keep us abreast of the developments within their technical proposal, their HCFA-PRO contract, and the dictates from HCFA. The Kansas Foundation for Medical Care (KFMC), our designated PRO, has provided an opportunity for Kansas hospitals to comment on the review requirements in its review plan and the hospital agreement. However, KFMC is severely restrained in the latitude they can use in responding to the concerns Kansas hospitals have voiced. We will continue to work with KFMC, and hopefully with HCFA, to develop an effective utilization program. However, this cannot be done if serious consideration is not given to hospitals' comments and to developing an attitude of working with the provider community (instead of an adversarial one). The health care industry is so complex that the federal government cannot afford to eliminate or ignore constructive comments from the provider community.

IV. Centralized, Non-Delegated Review

The PRO program being implemented currently by HCFA is solely a non-delegated, prescriptive review. Currently the program provides few rewards for those hospitals having effective in-house utilization management and peer review programs. While the Peer Review Improvement Act explicitly

allowed a PRO to establish subcontracts with hospitals that have demonstrated the ability to perform, HCFA has totally rejected the concept of hospital-based review. While we understand their concern that the review process has a significant bearing on payment, we also realize, if implemented improperly, it can have a significant negative bearing on hospitals' cost. HCFA's policy has two impacts that the Kansas Hospital Association is seriously concerned about:

1. Most of the review in Kansas will be conducted outside of the hospital at the PRO office. This will mean Kansas hospitals, primarily small and rural hospitals, will be photocopying large numbers of medical records. The HCFA-proposed regulations issued July 17 prohibit the PRO from paying hospitals for the costs incurred in copying and shipping medical records. And HCFA has explicitly excluded funds for this purpose from the PRO contracts. HCFA states these costs were covered under the cost reimbursement system and, consequently, reflected in the DRG prices. However, as we stated earlier, the volume of review and thus the records demanded has increased sharply under the new PRO procedures. Therefore, any costs borne in the past are far less than those currently being borne by Kansas hospitals.

   Once again, HCFA has managed to shift costs from the Medicare program to non-Medicare patients. Even those hospitals, where on-sight review will be performed, will be bearing additional costs not recognized by HCFA. In Kansas, these hospitals will be subject to a mandatory 100 percent review regardless of performance. This will

mean not only constantly making space available for the PRO review staff, but constantly making available medical record personnel and medical staff available to assist the PRO in their review.

Once again, because the volume of review has significantly increased, these costs were not included in the historical costs of hospitals. It is interesting to note that in the July 3 proposed rules governing Medicare's Prospective Payment System for fiscal year 1985 HCFA has managed to decrease the federal and hospital-specific rates for "improved inefficiencies in hospitals' medical record documentation and coding." However, HCFA has not likewise seen fit to increase those PPS rates for the additional costs hospitals are incurring because of the new PRO review procedures and the importance now being placed upon the medical record. Hospitals are having to increase the medical records staffing in order to comply with the increased importance and intensity being placed on the medical record.

Again, the PRO program as it is being implemented by HCFA does not provide incentives for good performers. A program encouraging the development of strong hospital-based review systems would better serve Medicare and its beneficiaries than one that removes the incentives to make utilization review a central part of hospitals' internal management structures. A competitively based program should reward efficient and good performers rather than establishing across the board penalties.

V. Data Confidentiality

In general, while the intent of the Peer Review Improvement Act was to protect against unauthorized access to confidential data and to specifically exclude PROs from the provisions of the Freedom of Information Act, the NPRMs issued by HCFA in April governing the acquisition, protection and disclosure of information by PROs emphasize circumstances when the PRO can release data and the obligation of the PRO to provide confidential and other information to the public. Specifically, the NPRM defined "confidential information" to include only information that explicitly or implicitly identifies an individual patient, practitioner or reviewer. The omission of hospitals from this definition renders all institution-specific information "non-confidential."

Section 1160(a) of the Peer Review Improvement Act requires the Secretary to promulgate regulations that "assure adequate protection of the rights and interests of patients, practitioners and providers." (Emphasis added.) Section 1160(b) requires the Secretary to "establish procedures and safeguards to protect individual patients, practitioners and providers from unnecessary disclosures." (Emphasis added.) While the April NPRM described potential results of public disclosure of practitioner-specific information, these examples of potential misrepresentation of data could equally apply to hospitals or the health care industry as a whole. For example, statistics demonstrating a high (but justified) ratio of patient deaths for a given hospital could be misleading to the public, particularly if the hospital's case-mix information is not supplied and fully explained as well. Such a misrepresentation of data is well demonstrated by a recent article printed in the Wichita Eagle Beacon, July 29, 1984. This article

which came from the New York Times News Service stated, "The Kansas contract said that 'data from October, 1983 to February, 1984 revealed a 7.8 percent rate of substandard hospital care' that forced patients to return to the hospitals for more treatment." This statement infers that 7.8 percent of the hospital care rendered in Kansas is substandard. What KFMC's technical proposal actually said was that in establishing a Kansas objective for the HCFA-mandated quality objective of "reducing unnecessary readmissions resulting from substandard care provided during the prior admission," the verification data used by the PRO to set this objective showed that "between October, 1983 through February, 1984, 64 readmissions within seven days from 10 Kansas hospitals were reviewed by KFMC. Of these readmissions, five (7.8 percent) were related to substandard care provided during the prior admission." (Emphasis added.) Five cases is a far cry from the 7.8 percent of all admissions that is being inferred from the article printed in the Wichita Eagle Beacon!

This shows the importance of maintaining the confidentiality of the data obtained by the PRO and the potential for misuse and misrepresentation when it is released to parties unfamiliar or uneducated in the medical arena. In addition to permitting the release of this type of information, the April NPRM only mandated that 15 calendar days notice be given to a provider before a PRO discloses information to a requesting party. Fifteen calendar days does not allow a provider adequate time to receive and comment upon the information to be disclosed.

While the April NPRM limited redisclosure of peer review information by persons or organizations receiving such information, once agencies other than the PRO have obtained confidential information the extent to which the

PRO can realistically guarantee the information's protection is seriously open to question. Congress itself acknowledged the problem of redisclosing this data by imposing the same penalties on the receiving agency for improper disclosure of information as would be imposed on the PRO. Although the April NPRM explicitly limits redisclosure, these provisions do not guarantee the protection of any information held by a public agency, including HCFA, from discovery under the Freedom of Information Act and other state laws. Therefore, it is essential that regulations specifically limit agencies and organizations to which the information would be available and specify what information can be provided. Under no circumstances should access to provider-specific or patient-specific information be provided, other than on-sight at the PRO, to any agency.

These are just a few of the concerns the Kansas Hospital Association has with respect to the lack of provisions to protect the confidentiality of data supplied to the PRO. Our comments to HCFA's April NPRM detail our concerns and suggestions. A copy of these comments has previously been given to the Senate Finance Committee staff.

VI. Physician Attestation

The January 3 regulation governing the Prospective Payment System for fiscal year 1984 required the attending physician to sign a statement at the beginning of the patient's chart certifying the accuracy of the description of the principle and the secondary diagnosis and the major procedures performed. The statement also included a notice stating anyone who misrepresents, falsifies or conceals essential information would be subject to fine, imprisonment or civil penalty.

With the HCFA-proposed regulations published July 3, some of our concerns have been eased. The proposed regulations modify the previous policy by requiring the physician to sign a statement specifically indicating that he or she is only certifying the narrative description of the principle and secondary diagnosis and the major procedures performed. We believe this statement now clarifies a number of concerns physicians had about potentially being held responsible for the actual coding of these diagnoses and procedures. However, HCFA did add a new requirement that the statement be located on the discharge summary sheet in the patient's record.

The Kansas Hospital Association believes it is too prescriptive to mandate that the attestation be on the discharge summary. Kansas hospitals have developed their own methods and procedures of documentation of the final diagnoses and procedures performed, unique to the individual hospital's and medical staff's needs and standard operating practices. Such practices were well established years prior to the 1984 required attestation statement.

Since the attestation statement's implementation, each hospital has developed its own method of compliance, taking into account what is most efficient for its medical staff and individual hospital circumstances. As such, a variety of formats exist throughout Kansas hospitals. These formats include the use of a separately developed DRG validation form, the medical record face sheet, the discharge summary or an equivalent means. The majority of Kansas hospitals appear to be using the face sheet or separate validation document rather than the discharge summary.

Requiring the use of the discharge summary as the sole acceptable document for the attestation will mean a considerable disruption of existing methods in many Kansas hospitals and a re-education of the medical staffs. Kansas hospitals have been using formats other than a discharge summary in order to ease any cash flow delays caused by a delay in completing the discharge summary. Most medical staff bylaws allow at least 30 days for the attending physician to complete the discharge summary. However, the medical record face sheet is often completed and signed by the physician shortly after a patient's discharge. The primary purpose of the medical record is to facilitate the patient's care and to serve as a communication tool among the health care professionals. Physicians and hospitals should not be placed in the position of being required to reconstruct the medical record for the secondary purpose of substantiating payment to the detriment of its primary purpose. The Kansas Hospital Association is adamantly opposed to the requirement of using solely the discharge summary for the attestation statement.

In general, we also believe the attestation statement is unnecessary. By virtue of the signature on the face sheet, discharge summary or other documents in the medical record where diagnoses and procedures appear in writing, the physician is already attesting to his narrative descriptions of the principle and secondary diagnoses and major procedures. Consequently, a written statement to that fact is redundant.

Furthermore, the signed acknowledgement by the physician certifying that he or she is aware of the penalties for misrepresentation, falsification or concealment also appears unnecessary. The narrative description of the diagnoses and procedures follow a procedure established since modern

medical record documentation began. The fact that those descriptions are now used to determine payment does not change the essence of an acceptable narrative description. Physicians are well aware the medical record and its contents constitute a legal document and thus consequences exist for any fraudulent or other illegal activities. Rather than burden all hospitals and physicians with obtaining a document to that effect, it would seem more prudent for the government to issue a one-time notice and then to prosecute the few physicians who may undertake such fraudulent acts, in the same manner that the government has prosecuted offending physicians for fraudulent activities in the past.

Again, KHA expresses our appreciation for the opportunity to present our views and recommendations concerning the implementation of the PRO program. The Kansas Hospital Association and its member hospitals want to be an active participant and partner in establishing an effective, innovative utilization review process for Medicare, rather than being merely a spectator or a non-entity in the process. We wish to provide constructive comments on the proposed policies and procedures, and work with HCFA and our area PRO to obtain an effective, cost-efficient program for not only Medicare, but Kansas hospitals and physicians as well.

We thank you for your continued interest in the implementation of the PRO program.

CLJ:dh

President
Frank E. Samuel, Jr

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August 2, 1984

Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-279-P
Room 309-6 Hubert H. Humphrey Building
200 Independence Avenue, Southwest
Washington, D.C. 20201

Re: Medicare Program; Changes to the Inpatient Hospital Prospective Payment System; and Proposed Fiscal Year 1985 Rates

Dear Sir or Madam:

The Health Industry Manufacturers Association (HIMA) submits these comments on the proposed rule of the Health Care Financing Administration (HCFA) on changes to the Medicare prospective payment system and proposed fiscal year 1985 rates.

HIMA, a national trade association, represents 320 manufacturers of medical devices and diagnostic products. These devices and diagnostics are widely used in hospitals in delivering inpatient services to Medicare beneficiaries. For this reason, HIMA companies are direcrly affected by HCFA's proposed rule.

HIMA has supported prospective payment from the beginning. Our comments today, offered in a spirit of cooperation, include recommendations for making the proposed rule consistent with the law's intent and with prudent implementation of the prospective payment system.

Policy Considerations

In addition to the significant, technical, and legal problems in the proposal, it demonstrates a fundamental policy failure.

The principal question to be asked about such a proposal is: Does it balance fairly the obvious and urgent demand for federal deficit reduction with the equally important goal of assuring that Medicare prospective payment will succeed? The answer is plain: The proposal does not achieve that balance. It pursues short-term budget savings at the expense of the prospective payment system.

Let us point out here that the issue is not how well all or some hospitals are faring under the DRG system. The issue, we repeat, is whether prospective payment is strengthened or weakened by the proposal.

Prospective payment is weakened for the following reasons:

1. The disingenuous way in which HCFA's decision was revealed suggests disrespect for providers. This is not calculated to increase faith in the custodians of prospective payment.

2. The lack of data underlying the decision makes it impossible to evaluate the financial merits of the proposal. Particularly in its initial phases, the prospective payment system will benefit from full disclosure of the why's and wherefore's of any significant proposal.

3. Entirely apart from whether the lack of data violates the Administrative Procedure Act, HCFA has not satisfied the prospective payment law's disclosure requirements.

4. Even if HCFA reveals adequate data, the proposal is faulty because it is explicitly intended to penalize hospitals for doing exactly what prospective payment intends: Cut their costs and restrain the federal budget creep.

Overview of Specific Comments

Our specific comments speak in large measure to HCFA's (i) adjustment for budget neutrality and (ii) reduction of Diagnosis Related Group (DRG) weighting factors by 2.4 percent. Our comments make the following points:

- The proposed rule does not satisfy the law's requirement that the data and methodology underlying the budget neutrality and DRG weight adjustments be adequately described.

- Reducing DRG weights at this time is unjustified, because HCFA has not shown that the higher case mix values resulted solely from reporting of more accurate and complete patient information.

- By proposing to adjust DRG weights, HCFA has attempted a recalibration without satisfying the law's requirements for a recalibration.

- Finally, to remedy defects in the proposal outlined above, HIMA recommends that HCFA (i) disclose the data and methodology underlying the budget neutrality and DRG weight adjustments and (ii) perform a valid recalibration.

Our comments also explain that the Deficit Reduction Act of 1984 does not operate to reduce fiscal year 1985 prospective payment rates.

Specific Comments

I. The Proposed Rule Does Not Adequately Describe The Data And Methodology Underlying The Budget Neutrality And DRG Weight Adjustments.

HCFA has made a highly complex adjustment for budget neutrality. The reduction in DRG weights is similarly complex, especially with respect to the study on which the reduction was based.

For neither of these adjustments has the agency adequately described the underlying data and methodology. Without an adequate description, HIMA and others affected by the adjustments cannot fully understand them and evaluate their accuracy.

A. What The Law Requires

Adequate description of data and methodology is a key requirement of the prospective payment law. Section 1886(d)(6) of the Social Security Act states:

> The Secretary shall provide for publication in the Federal Register, on or before September 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates ... including any adjustments [for budget neutrality].

This is no *pro forma* requirement. With a system as complex and far-reaching as prospective payment, it is imperative that those affected by the payment rates understand how they were computed.

Congress clearly intended meaningful disclosure. The House Committee on Ways and Means, referring to Section 1886(d)(6), said:

> Your Committee believes this requirement for open publication and description of data is important to assure confidence among the affected parties in the integrity of the payment system, the adequacy of the data, and the accuracy of the calculations involved.

House Report 98-25, part 1, page 136.

Similarly, the conference report on the Deficit Reduction Act of 1984 indicates concern about HCFA's process for calculating budget neutrality for fiscal year 1985:

> Recognizing that budget neutrality will be a primary consideration in the establishment of the fiscal year 1985 hospital payment rates, the conferees are nevertheless concerned about the perception that they may be unfair and inequitable. The conferees realize that the appropriateness of the new levels of payment will be vital to the success of the full implementation of the prospective payment system ... [T]he conferees urge the Secretary to carefully evaluate the potential impact of the proposed rates on the long-term success of the prospective payment system.

House Report 98-861, page 1298.

The law thus imposes a strict burden on HCFA to describe fully the data and methodology underlying both the adjustment for budget neutrality and the 2.4 percent reduction in weights.

B. Budget Neutrality: Data and Methodology Omitted

The proposed rule and accompanying preamble do not satisfy Section 1886(d) because they omit key information on data and methodology.

Particularly nettlesome is omission of information on the budget neutrality adjustment. This adjustment

must necessarily involve a methodology as complex as its database is voluminous. Perhaps more than any other adjustment, budget neutrality points up the "data-driven" nature of prospective payment.

Specifically, the proposed rule omits the following information on the critical budget neutrality adjustment:

- Data and methodology used to estimate cost per discharge and total outlays under TEFRA and prospective payment.

- Studies described in the proposed rule's preamble, addendum, and appendix.

- Adjustments, assumptions, and formulae underlying the evaluations.

- Any changes in methodology and assumptions from fiscal year 1984 to fiscal year 1985 other than those outlined on pages 27433 and 27458.

Further, the proposed rule states that HCFA has "estimated average payments for both regional and national rates based on early data under the prospective payment system." We question the use of this early data that are not representative of all hospitals which are currently under prospective payment. Indeed, HCFA data indicate that only 42 percent of all hospitals were operating under prospective payment during this period. More detail on this data and its use must be disclosed.

C. DRG Weight Adjustments: Data and Methodology Omitted

The proposed rule reduces DRG weights to reflect, according to HCFA, increased accuracy and completeness of patient bills. This, says HCFA, has resulted in higher than expected case mix values -- a "distortion" that warrants a downward adjustment in hospital payments. 49 FR 27442-3.

As with budget neutrality, the reduction in DRG weights is a complex adjustment resting on data not disclosed in the proposed rule or its preamble. For HIMA and other parties to assess the adjustment, HCFA

should disclose the data and supporting studies and methodology.

We are particularly concerned about the methodology because of the sample of cases used in the analysis. We question the use of the 896,000 discharges. Significant variability exists among hospitals with respect to changes in the case mix. This small sample of discharges from a limited number of hospitals does not represent the actual variability in case mix since the sample of hospitals is not representative of all hospitals under prospective payment.

II. Reducing DRG Weights At This Time Is Unjustified Because HCFA Has Not Demonstrated That The Higher Case Mix Values Resulted Solely From More Accurate And Complete Patient Information.

As noted above, HCFA stated it is proposing to reduce the DRG weights to reflect improved medical recordkeeping and reporting of patient diagnoses and procedures under prospective payment. According to HCFA, these improved coding practices would not have occurred under the Tax Equity and Fiscal Responsibility Act (TEFRA). As such,

following HCFA's reasoning, budget neutrality requires a downward adjustment (since, without this, improved coding would drive prospective payment outlays above the level that would have been spent under TEFRA).

HIMA strongly doubts the higher case mix values resulted solely from improved coding practices that would not have occurred under TEFRA. And as noted in the previous section of our comments, HCFA has certainly not disclosed the data and methodology that would support this claim.

However, while differing in detail, TEFRA gives hospitals a similar incentive as prospective payment -- the incentive to control costs. One important step in controlling costs is understanding the source of the costs by maintaining better patient information. HIMA thus believes it is incorrect to assume hospitals would not have improved their coding practices under TEFRA.

Further, HCFA itself notes that some of the increase in case mix values may be attributed to changes in hospital behavior, such as --

> ... conscious management decisions ... to specialize more strongly in certain DRGs having relatively high

> relative weights, and thereby increase the proportion of total admissions currently assigned to high weighted DRGs.

49 FR 27443.

What HCFA is observing -- more patients in higher DRGs -- could result from something other than management decisions and improved coding. It could be that hospitals are simply treating patients who happen to have more complicated conditions than was expected. If so, those patients would have been just as ill under TEFRA.

By assuming that all case mix value increases resulted from prospective payment-induced activities, the proposed rule unduly penalizes hospitals genuinely treating sicker patients. In fact, case mix value increases could have been experienced and paid for under TEFRA. Section 1886(b)(4)(A) of the Social Security Act provides authority to pay for case mix changes.

For the reasons above, HIMA believes the proposed rule incorrectly assumes prospective payment to be the sole reason for increased case mix values. This calls into serious question HCFA's downward adjustment to the weights for budget neutrality.

Most importantly, we observe that to the extent that the proposed rule is correct -- that hospitals really are operating more cost consciously under prospective payment -- those hospitals are penalized for responding in the very ways the law intended. This perversity, as well as the proposed reduction in weights when hospitals may be actually treating sicker patients, will damage the long-term success of the prospective payment system. As we noted on page 7 above, the Deficit Reduction Act conferees expressed concern about payments being so low that they could damage the long-term visibility of prospective payment.

III. By Proposing To Adjust DRG Weights, HCFA Has Attempted A Recalibration Without Satisfying The Law's Requirements For A Recalibration.

A. What the Law Requires

Section 1886(d)(4)(B) of the Social Security Act provides that for each DRG the Secretary must "assign an appropriate weighting factor which reflects the relative hospital resources used" for discharges in that

DRG, compared to discharges in other DRGs.

Once a weighting factor is assigned, it can only be changed through recalibration, as provided under Social Security Act Section 1886(d)(4)(C):

> The Secretary shall adjust the ... weighting factors established under [Section 1886(d)(4)(B) quoted above], for discharges in fiscal year 1987 and at least every four fiscal years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

The point, then, is that by proposing to change the weights, HCFA is necessarily proposing a recalibration. But as we explain below, the agency's proposed weight adjustments does not satisfy the law's requirements for a recalibration.

B. Inadequate Basis for HCFA's Weight Adjustments

The fact that HCFA's proposed adjustment to the weights is a uniform 2.4 percent reduction makes clear that the adjustment cannot qualify as a valid recalibration. The concept of recalibration is one of

relativity -- changes in the weights must reflect changes in "the relative use of hospital resources." Social Security Act, Section 1886(d)(4)(C).

Congress reserved annual updating of average standardized amounts as the mechanism for adjusting DRGs uniformly. Social Security Act, Sections 1886(d)(3)(A), 1886(e)(4). To make an across-the-board adjustment to the weights is to reject the DRG-specific adjustments the law contemplates for recalibration.

C. Making the Recalibration Valid

HCFA believes case mix values have increased because of improved coding practices. To the extent HCFA is correct, it should account for these improvements through a valid recalibration that recognizes the significant variability in hospital resource allocation among DRGs.

More specifically, any true coding improvements point up underlying flaws in the way the DRG weights account for relative use of hospital resources -- the key factor that makes recalibration appropriate. That is,

the fact that coding is being improved means that the discharges now being classified in correct DRGs were classified in incorrect DRGs when the weights were constructed. As a consequence, some weights may be understated, others overstated.

The way to fix this is through a proper, DRG-by-DRG recalibration. Proper recalibration would account for variability by measuring intra-DRG resource changes and adjusting weights according to the changes.

To the extent the analysis identifies true coding improvements, appropriate weight adjustment should be made. To the extent HCFA discovers increased case mix values are attributable to other factors, appropriate amounts should be restored to the weights across the board to compensate for the incorrect 2.4 percent uniform reduction.

IV. HIMA Recommends That HCFA's Proposed 2.4 Percent Reduction Be Added Back To The Weights (Without Any Parallel Downward Adjustment For Budget Neutrality).

A. Remedies For Defects Outlined Above

HIMA suggests the following remedies for the defects

in the proposal outlined above:

- The remedy for the inadequate description of the data and methodology used to compute budget neutrality and the reduction in weights (as outlined in Section I of the comments) is for the agency to make an adequate disclosure.

- The remedy for the unjustified reduction in the weights (Section II of the comments) and for the invalid recalibration (Section III of the comments), is for the agency to perform a valid recalibration.

- HCFA should issue an interim final rule for the period during which the agency is (i) disclosing data and methodology and (ii) performing a valid recalibration. For the period covered by the interim final rule, HCFA should add back to the weights the proposed 2.4 percent reduction.

- To the extent the HCFA discovers that the increased case mix values resulted from factors other than improved coding, the agency should issue a final

rule restoring appropriate amounts to the weights across the board to compensate for the incorrect 2.4 percent uniform reduction.

B. Issuing An Interim Final Rule

HCFA has authority to issue an appropriate interim final rule for fiscal year 1985*. HIMA urges HCFA

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* Section 604(c) of the Social Security Amendments of 1983 provides this authority.

That section provides the following procedures for issuing an interim final rule for Fiscal Year 1984:

- The Secretary publishes an interim final rule not later than September 1, 1983, and allows a period for public comments.
- Payments under the interim final rule become effective October 1.
- Based on public comments, the Secretary, not later than December 31, affirms or modifies the prospective payment rates. Any modification that reduces rates applies only to discharges occurring after 30 days after the date of the modification.

Section 604(c) describes the above procedures in specific terms. The section refers to the fiscal 1984 interim final rule as "the interim final DRG prospective payment rates established under subsection (d) of Section 1886 of the Social Security Act." (Section 1886(d) is the section that establishes prospective payment rates.)

Despite these specific references to interim final prospective payment rates for fiscal 1984, Section 604(c) concludes with this more general paragraph:

> Rules to implement subsection (d) of Section 1886 of the Social Security Act ... should be established in accordance with the procedure described in this subsection.

to use this authority to allow time for (i) adequate disclosure of data and methodology and (ii) a valid recalibration of DRG weights.

Specifically, not later than September 1, HCFA should issue an interim final rule effective October 1 that adds back to the weights the proposed 2.4 percent reduction.

Until December 31, HCFA should disclose data and methodology and perform a valid recalibration. Based on public comments, HCFA should affirm or modify the interim final rates. Any modification that reduces rates would apply to discharges occurring after 30 days after the date of the modification.

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* (Continued from previous page.)

HIMA believes this general paragraph is intended to apply the rules for issuing fiscal year 1984 interim final rates to fiscal years in addition to fiscal year 1984. That is, the general paragraph quoted above -- applicable on its face to rules to implement prospective payment rates for any fiscal year -- simply incorporates by reference the procedures prescribed specifically for fiscal year 1984.

To construe the general paragraph differently would be to say it has no effect. For such a construction would mean that the general paragraph refers only to the procedure for issuing fiscal 1984 interim final rates -- making the general paragraph superfluous, since fiscal 1984 interim rates are clearly and specifically dealt with elsewhere in Section 604(c).

Adhering to this procedure would give all affected parties the opportunity to participate meaningfully in the rulemaking process. By allowing time to review the complex data and methodology (or what would be a complex recalibration), affected parties could assess the accuracy of HCFA's computations and make more thorough comments. If HCFA still believed its computations were correct, it could issue the rates in the final form it wished on December 31 (though any reductions from the rates could not be applied retroactively).

V. HIMA Believes The Deficit Reduction Act of 1984 Does Not Reduce Fiscal Year 1985 DRG Rates.

The Deficit Reduction Act would revise the annual updating factor from the hospital marketbasket plus one percentage point to marketbasket plus 0.25 percentage point. The law changes this formula for both TEFRA and prospective payment calculations.

A. No Change In Computation of Budget Neutrality

Budget neutrality is computed with reference to

"payment amounts which would have been payable ... under the law as in effect before the date of the enactment of the Social Security Amendments of 1983." Social Security Act, Section 1886(e)(1)(B)(ii) (emphasis supplied). Thus, fiscal year 1985 payments must equal the estimated aggregate payments that would have been made under TEFRA --as TEFRA existed before prospective payment (not TEFRA as TEFRA was amended in the Deficit Reduction Act).

Complementing the plain language of the statute is House Report 98-25, Part 1, page 134, which describes budget neutrality with reference to "reimbursement provisions that would have applied under the 1982 TEFRA legislation." (Emphasis supplied.) Accord: Senate Report 98-23, page 50.

B. No Reduction In Fiscal 1985 Rates

Budget neutrality requires adjustment of average standardized amounts so that "aggregate payment amounts" for Fiscal Year 1985 equal estimated aggregate payments that would have paid under TEFRA. Social Security Act, Section 1886(e)(1)(B).

Similarly, the preamble to the proposed rule notes that while --

> the budget neutrality adjustment is calculated on a per discharge basis ... the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred had the prior legislation remained in effect.

49 FR 27458 (emphasis supplied.)

So the aggregate payment that would have been incurred under TEFRA is the level that should be spent under prospective payment. Based on the limited information supplied in the proposed rule, HIMA believes cutting real growth in hospital costs per case from 1 percent to 0.25 percent -- as provided in the Deficit Reduction Act -- would not drive the aggregate payment level below the budget neutrality level, because fiscal year 1985 payments must equal that level. The Act's cut in per case costs, then, would appear not to have any effect on the fiscal year 1985 payment computation.

Conclusion

For the reasons outlined above, HIMA believes HCFA should revise the proposed rule in the manner suggested. This would be important to the sound implementation of prospective payment in fiscal year 1985 and to the long-term viability of the system. We pledge our assistance in this effort.

Sincerely,

Frank E. Samuel Jr.

cc: Carolyne K. Davis
Patrice H. Feinstein